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No. 08-558

In The

Supreme Court of the United States

ROBERT I. BOURSEAU; RIB MEDICAL MANAGEMENT SERVICES, INC.; RUDRA SABARATNAM; AND NAVATKUDA, INC.,

Petitioners,

v.

UNITED STATES OF AMERICA,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

PATRIC HOOPER (SBN 57343)
HOOPER, LUNDY & BOOKMAN, INC.
1875 Century Park East, Suite 1600
Los Angeles, CA 90067-2799

Tel: (310) 551-8165
Fax: (310) 551-8181

Attorneys for Petitioners

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTIONS PRESENTED

1. Whether the Court of Appeals, in conflict with the Eighth Circuit, but consistent with the Fourth and Sixth Circuits, correctly concluded that the "natural tendency test," rather than the "outcome materiality test," should be used to determine if the false Medicare cost reports at issue were material to a payment decision of the government under the Federal False Claims Act ("FCA") 31 U.S.C. § 3729-3733.

2. Whether the Court of Appeals in conflict with the Third, Fifth and District of Columbia Circuits, correctly concluded that the government sustained damages even though the government failed to prove it relied on the false representations in the Medicare cost reports.

3. Whether the Court of Appeals in conflict with an earlier Ninth Circuit decision and relevant decisions of this Court correctly concluded that there is "no law" requiring a district court to award less than treble damages and the maximum amount of allowable civil penalties under the FCA to satisfy the excessive fines clause of the Eighth Amendment and the due process clause of the Fifth Amendment.

PARTIES TO THE PROCEEDINGS

The Petitioners, Defendants/Appellants below, are Robert I. Bourseau; RIB Medical Management, Inc.; Rudra Sabaratnam; and Navatkuda, Inc.

The Respondent, Plaintiff/Appellee below, is the United States of America.

CORPORATE DISCLOSURE

Petitioner RIB Medical Management Services, Inc. ("RIB") is not a publicly held corporation and is wholly owned by Petitioner Robert I. Bourseau. Petitioner Navatkuda, Inc. ("Navatkuda") is not a publicly owned corporation an is wholly owned by Petitioner Rudra Sabaratnam.

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PETITION FOR A WRIT OF CERTIORARI

OPINIONS BELOW

The opinion of the Court of Appeals (App. at 1-33) is reported at 531 F.3d 1159. The opinion of the District Court (App. at 34-80) is not published in the official reports but is published at 2006 WL 2961105 and 3949169.

JURISDICTION

The judgment of the Court of Appeals was entered on July 14, 2008. The Order Denying Rehearing (App. at 83-84) was entered on August 19, 2008, and the Mandate (App. at 81-82) issued August 27, 2008. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1). The Court of Appeals exercised jurisdiction to review the District Court's decision under 28 U.S.C. § 1291. The District Court asserted jurisdiction under 31 U.S.C. § 3732(a) and 28 U.S.C. § 1345.

CONSTITUTIONAL PROVISIONS INVOLVED

The Eighth Amendment to the United States Constitution provides, in pertinent part, that excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted. The Fifth Amendment provides, in pertinent

part, that no person shall be deprived of life, liberty or property without due process of law.

THE RELEVANT STATUTES

31 U.S.C. § 3729(a)(7) states in pertinent part that any person who knowingly makes, uses, or causes to be made or uses a false record or statement to conceal, avoid or decrease an obligation to pay money to the government is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages which the government sustains because of the act of that person.

STATEMENT OF THE CASE

A. The Medicare Reimbursement Process

This case involves the submission of three Medicare cost reports and thus a brief review of the Medicare reimbursement process is necessary. During the period at issue, Medicare reimbursed psychiatric hospitals for the reasonable costs of services provided to Medicare beneficiaries. 42 U.S.C. §§ 1395k, 1395ww(b), 1395x(v)(1)(A); 42 C.F.R. § 412.23. Medicare reimbursed such providers only for the portion of costs that relate to Medicare patients. 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 413.50. *See* Court of Appeals Opinion, App. at 3.

The Medicare program contracts with private insurance companies, known as Medicare fiscal intermediaries, to facilitate the reimbursement process. 42 U.S.C. § 1395h; 42 C.F.R. § 413.64. The fiscal intermediaries pay providers interim amounts periodically throughout the year based on estimated treatment costs for Medicare patients. 42 U.S.C. § 1395g(e); 42 C.F.R. §§ 413.60 and 413.64. At the end of the year, providers submit a final accounting of their actual costs for the year to their intermediaries in a document called a cost report. 42 C.F.R. § 413.20. Court of Appeals Opinion, App. at 3-4.

To reimburse providers for their Medicare costs as quickly as possible, fiscal intermediaries are required to make an initial retroactive adjustment (also known as "tentative settlement") to the aggregate interim payments as soon as they receive the provider's cost report. 42 C.F.R. § 413.64(f)(2); Provider Reimbursement Manual ("PRM") § 2408.2 (App. at 85-86). In making the initial retroactive adjustment, intermediaries accept costs as they are reported on a cost report except for obvious errors and inconsistencies. 42 C.F.R. § 413.64(f)(2); PRM § 2408.2. The cost reports are later subject to audit by the fiscal intermediaries. 42 C.F.R. § 413.64(f)(2). Court of Appeals Opinion, App. at 4.

After fiscal intermediaries audit a cost report, they determine the provider's and the Medicare program's final liability to one another. 42 C.F.R. § 413.64(f)(2). In other words, an intermediary typically uses a cost report to determine whether a

provider or Medicare is owed money at "final settlement" of the cost report based on the difference between the aggregate interim payments already made to the provider and the actual amount that the intermediary determines was actually due the provider based on the audit of the cost report. 42 C.F.R. §§ 405.1803, 413.9(b)(1), 413.60, and 413.64(f). Recoupment of any overpayment made to a provider occurs notwithstanding any request for a hearing to review an intermediary's determination. 42 C.F.R. § 405.1803(c). Court of Appeals Opinion, App. at 4-5.

The Medicare regulations governing reasonable cost reimbursement are voluminous and complex. As of 1994, they consumed 624 pages of the Code of Federal Regulations (Title 42). *Shalala v. Guernsey Memorial Hosp.*, 514 U.S. 87, 90, 96 (1995). Because of their complexity, Congress established the Provider Reimbursement Review Board to resolve disputes pertaining to the definition of reasonable costs. *See United States v. California Care Corp.*, 709 F.2d 1242, 1248, footnote 9 (9th Cir. 1983). For those particular details not addressed by Medicare reasonable costs regulations, the Secretary of Health and Human Services, who administers the Medicare program, relies on "an elaborate adjudicative structure," which includes the Provider Reimbursement Review Board. *See Shalala v. Guernsey Memorial Hosp.*, 514 U.S. at 96, citing 42 U.S.C. § 1395oo(f)(1). Thus, Medicare reasonable cost reimbursement is typically

determined through rulemaking and adjudication. *Id* at 96-97.

Importantly, unlike a federal tax return, a Medicare cost report serves as the beginning point for determining reasonable costs as opposed to the endpoint. In *Shalala v. Guernsey Memorial Hosp.*, 514 U.S. at 94, this Court expressly recognized this fact emphasizing that a provider's Medicare cost reporting is the first step toward reimbursement and certainly not the only or last step. The Medicare fiscal intermediaries must assist providers in interpreting and applying the principles of Medicare reasonable cost reimbursement to the cost reporting process.

In other words, the process for determining Medicare reasonable costs consists of "more than a provider handing over its" cost report to its fiscal intermediary. Numerous subsequent actions, including a thorough review of the cost report, are required to determine the liability of the Medicare program for services previously rendered. 514 U.S. at 94. None of these steps occurred here because, as stressed below, the fiscal intermediary deliberately chose not to act on the cost reports at issue due to the provider's precarious financial status.

Additionally, the courts have interpreted the Medicare Act to hold that unless a provider includes a cost in a cost report, the provider loses its right to pursue reimbursement through the Medicare administrative appeal process. *See Athens Community Hosp., Inc. v. Schweiker*, 743 F.2d 1 (D.C. Cir. 1984).

Indeed, unless a fiscal intermediary makes an "adverse decision" regarding particular costs in a cost report, the provider is precluded from pursuing an appeal of such costs with the Provider Reimbursement Review Board. 743 F.2d at 3, footnote 2.

As discussed further below, it is undisputed in this case that the three Medicare cost reports at issue, were not, in fact, acted on by the Medicare fiscal intermediary, and thus *no payment decisions were made by the responsible government agent* based on the three cost reports, because the fiscal intermediary determined that the Medicare provider was involved in bankruptcy proceedings or otherwise insolvent. Under a Medicare PRM provision, specifically Section 2408.2 (App. at 85-86), no action is taken on a cost report submitted by a provider when the provider is potentially insolvent or is the subject of bankruptcy proceedings.

Although this manual provision appears to be inconsistent with 42 C.F.R. § 413.64(i) (App. at 87-98), which requires an intermediary to adjust interim payments in a bankruptcy or insolvency situation, it is undisputed in this case the fiscal Medicare intermediary chose to take *no such action* in response to the three cost reports because of the hospital's pending bankruptcy and insolvency. In other words, as discussed below and as recognized by the Court of Appeals, the fiscal intermediary made no payment decision, including adjusting Medicare interim rates, based on the receipt of the three cost reports at issue. However, because the Court of Appeals concluded

that the Medicare fiscal intermediary could have potentially taken some payment action, the submission of the false cost reports was material to a Medicare payment decision and thus actionable under the FCA.

B. The Facts

Between 1994 and 2000, Bayview Hospital and Mental Health Systems ("Bayview") was a psychiatric hospital that participated in the Medicare program. Bayview was owned and operated by a California limited partnership, known as California Psychiatric Management Services ("CPMS"), which, in turn, was owned by Mr. Bourseau and Dr. Sabaratnam through their wholly owned corporations, RIB and Navatkuda. Court of Appeals Opinion, App. at 5.

In 1996, well before the cost reports at issue were prepared or even contemplated, CPMS filed for Chapter 11 bankruptcy protection. At the time, its only business was Bayview. By letter dated July 16, 1997, the Medicare fiscal intermediary informed Bayview that it was resetting Bayview's Medicare interim payment rates based on Bayview's 1996 Medicare cost report. Exhibit J-66, App. at 99-100. The 1996 cost report predates the three cost reports at issue here. By a second letter also dated July 16, 1997, the same Medicare fiscal intermediary informed Bayview that because of Bayview's bankruptcy proceedings, no further adjustments would be made to Bayview's cost reports. Defendants' Exhibit A, App. at 101-102.

Although CPMS emerged from bankruptcy in 1998, it sought bankruptcy protection again in 2000. Court of Appeals Opinion, App. at 7. Throughout the period of 1996 through 2000, the Medicare fiscal intermediary treated Bayview as being in bankruptcy or insolvent. Thus, the Medicare fiscal intermediary deliberately chose to *make no payment determinations* based on Bayview's 1997, 1998 or 1999 Medicare cost reports, the three cost reports at issue. In fact, the District Court expressly found that the government failed to prove it expressly relied on the false representations in the three cost reports. Dist. Ct. opinion, App. at 68.

The Court of Appeals thus confirmed that (1) Bayview's Medicare fiscal intermediary, Mutual of Omaha, never made adjustments to Bayview's 1997, 1998 and 1999 cost reports, (2) never audited these three cost reports, and (3) never collected overpayments or paid underpayments based on any of these three cost reports. Court of Appeals Opinion, App. at 7. Indeed, Bayview's interim Medicare payment rates, which had been adjusted in 1997 based on Bayview's 1996 cost report, remained the same between 1997 and 2000 because of the bankruptcy.

However, as discussed below, the Court of Appeals nevertheless concluded that because the false cost report entries in Bayview's 1997, 1998 and 1999 Medicare cost reports had the potential or natural tendency to affect Bayview's interim Medicare payment rates through impeding the fiscal intermediary's ability to adjust the interim rates, they were

material to a Medicare payment decision. Court of Appeals Opinion, App. at 27, 28-29.

C. The Proceedings Below

The government filed suit against Petitioners in the United States District Court for the Southern District of California alleging violations of the FCA, unjust enrichment and common law fraud. After a six day bench trial, the District Court held the Petitioners to be jointly and severally liable to the government under the FCA. The District Court concluded that the 1997, 1998 and 1999 cost reports were false claims which were actionable as both affirmative false claims and reverse false claims. According to the District Court, by including the false costs in the cost reports, Bayview had decreased the amount it owed Medicare by $5,219,195, which required the District Court to impose treble damages of $15,657,585 and $31,000 in civil penalties. Court of Appeals Opinion, App. at 8.[1]

The District Court, however, concluded that the government failed to prove that Petitioners were liable under the unjust enrichment and common law fraud causes of action. Indeed, the District Court

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[1] The District court originally held that treble damages were in excess of $24,000,000. App. at 57. However, the parties pointed out this approximately $9,000,000 mistake in a post-trial motion, and the District Court altered its opinion accordingly. App. at 75.

expressly concluded that the government did not prove it "relied on the false representations" in the cost reports. *See* District Court's September 29, 2006 Decision, App. at 68.[2] Notwithstanding these holdings, the District Court separately concluded that the award of maximum treble damages and civil penalties did not violate either the excessive fines clause or the due process clause of the Constitution. *See* District Court's December 1, 2006 order, App. at 75-79.

Petitioners timely and separately appealed the District Court judgment. The Court of Appeals consolidated the appeals and affirmed the District Court's judgment. However, the Court of Appeals analyzed the Medicare cost reports under the reverse false claims provision of the FCA, 31 U.S.C. § 3729(a)(7) and not under the provisions of (a)(1), (a)(2) or (a)(3).[3]

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[2] The Court of Appeals, however, makes no mention of these conclusions in its opinion and did not rehear or amend its opinion to account for these conclusions, which were again emphasized in the previously filed petition for rehearing.

[3] Although the Court of Appeals analyzed the cost reports under the reverse false claim provision of the FCA, it stated in dicta (*see* footnote 1 of the opinion, App. at 9), that the cost reports were also actionable claims under the affirmative claims provisions of the FCA. Most respectfully, this dicta is plainly erroneous. *See Rabushka ex rel. U.S. v. Crane Co.*, 122 F.3d 559, 565, footnote 8 (8th Cir. 1997), where the Court confirms that every circuit, including the Ninth Circuit, to have considered the issue has concluded that a reverse false claim was not actionable until Subsection (a)(7) was added to the FCA in 1986. Because

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The Court of Appeals concluded that the government proved each and every element necessary to establish liability under the reverse false claim provision of the FCA, 31 U.S.C. § 3729(a)(7), including materiality. In doing so, the Court of Appeals recognized that a materiality requirement existed under the FCA, especially under the reverse false claims provision of the FCA. Court of Appeals Opinion, App. at 25-27. The Court further noted the split of authority among the Courts of Appeals on the test to be used for determining materiality under the FCA. Choosing to side with the Fourth and Sixth Circuits, the Court of Appeals adopted the "natural tendency test" for determining materiality in this case, which focuses on the "potential effect of the false statement when it is made rather than on the false statement's actual effect after it is discovered." The Court noted that the Eighth Circuit had adopted a more restrictive "outcome materiality" standard, which required the government to show that the defendants' actions actually caused the United States to pay out money it was not obligated to pay or actually deprived the United States of money it was lawfully due. Court of Appeals Opinion, App. at 26.

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the three cost reports at issue did not make any actual claim for payment but rather reported costs which had the potential to decrease the amount owing the government, they were reverse false claims, not affirmative false claims. Thus, they were actionable only under (a)(7).

Under the natural tendency test, the Court of Appeals concluded that the false entries in the 1997, 1998 and 1999 cost reports were material because they had the "potential effect, or natural tendency" to decrease the amount Bayview (CPMS) owed Medicare despite the fact the cost reports were never acted upon. Court of Appeals Opinion, App. at 27. This conclusion squarely poses the materiality issue raised by the first question on which review is requested.

Moreover, the Court upheld the District Court's judgment awarding the maximum civil penalties and treble damages calculated by the government's expert witness using a "what if" calculation, which determined the impact of the false cost report entries as if the cost reports had actually been acted and relied upon by the Medicare fiscal intermediary when, in fact, they never were acted or relied upon. Thus, although the Medicare fiscal intermediary did not process the cost reports and did not use them to review or alter Bayview's Medicare's interim payment rates or tentative or final settlements and did not issue any demands for payment upon the receipt of the cost reports (or in the words of the District Court – did not rely on the misrepresentations), the Court of Appeals nevertheless upheld the "what if" damages calculation made by the government's expert at trial. This conclusion poses the damages causation issue raised by the second question on which review is requested.

Finally, even though the District Court concluded that the government failed to prove common law

fraud and failed to prove that any of the Petitioners had been unjustly enriched as a result of the filing of the cost reports and even though there was no *qui tam* relator with whom the government would have to share the proceeds of the judgment, the Court of Appeals concluded that the District Court's judgment was constitutionally sound, i.e., not excessive or disproportional. In doing so, it found "no law requiring a District Court to award less than treble damages and the maximum amount of allowable civil penalties in an FCA case in order to satisfy the Excessive Fines Clause." Court of Appeals Opinion, App. at 81-83. This conclusion poses the excessive damages issue, the third question on which review is requested.

REASONS FOR GRANTING THE PETITION

A. The Importance of the Questions

As this Court has noted, the FCA is the government's primary litigative tool for "recouping losses suffered through fraud." *Vermont Agency of Nat. Resources v. U.S.*, 529 U.S. 765 (2000). The resolution of the questions presented here is critical to the uniform application of the FCA to all types of government contractors. The questions are especially important, however, to the health care industry where health care fraud cases currently surpass all other types in which the FCA is used. *See 1 John T. Boese, Civil False Claims and Qui Tam Actions,* 1-36

through 1-38 (3d Ed. Supp. 2008) and *Robert Salcido, Health Care Fraud and Abuse: Practical Perspectives*, American Bar Association, Health Law Section, Chapter 3.1 (Linda A. Baumann, Editor 2002).

This Court has provided continuing guidance on FCA issues, including those issues regarding the nature of FCA damages and penalties. *See Vermont Agency of Nat. Resources v. United States ex rel. Stevens,* 529 U.S. 765, 784 (2000) and *Cook County v. United States ex rel. Chandler,* 538 U.S. 119, 130-31 (2003). The related question of the limits on punitive damages in civil actions is also of great concern to the Court from a due process standpoint. *See State Farm Mutual Automobile Insurance Company v. Campbell*, 538 U.S. 408, 429 (2003). Indeed, in *Exxon Shipping Company v. Baker,* ___ U.S. ___, 128 S. Ct. 2605 (2008), this Court recently concluded that a one-to-one ratio of punitive to compensatory damages was a fair upper limit in most maritime law cases.

B. The Decision Deepens a Conflict Among the Lower Courts Allowing the Government to Pursue Actions Based on False Claims and Representations Which Do Not Actually Affect Government Payment Decisions

As explained above, the government made no payment decision based on the submission of the three cost reports at issue here. Significantly, this is precisely why the District Court concluded that the government failed to prove common law fraud. *See*

page 21 of the District Court's decision, App. at 58, where among other things, the District Court concludes that the government failed to prove it "relied on the false representations" at issue. Notwithstanding this finding, the Court of Appeals applied the "natural tendency test" to hold that the cost reports were material because they had the potential to affect a government payment decision even though they did not, in fact, do so here.

This application of the natural tendency test demonstrates why it should be rejected as the test for materiality under the FCA. Yet, the Ninth Circuit has now joined the Fourth and Sixth Circuits in adopting the natural tendency test as the basis for determining materiality under the FCA. As the Ninth Circuit recognized, its decision to adopt the natural tendency test is contrary to the Eighth Circuit's decision adopting the "outcome materiality test." Under this latter standard, the government must prove that the false claim or false representation actually deprived the government of money it was lawfully due.[4]

A leading commentator, John T. Boese, on whom this Court and others, including the Ninth Circuit, have relied in interpreting the FCA (*see*, for example, *Hughes Aircraft Co. v. United States ex rel. Schumer,*

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[4] In *U.S. ex rel. Costner v. U.S.*, 317 F.3d 883, 886-87 (8th Cir. 2003), the Court stated that although the Courts disagree about the proper standard for materiality under the FCA, its previous decisions suggest that "outcome materiality" is the proper standard.

520 U.S. 939 (1997)) discusses in detail the need to clarify the standard for determining materiality under the FCA. *See 1 John T. Boese, Civil False Claims and Qui Tam Actions* at 2-158.6 through 2-192 (3d Ed. Supp. 2008). To avoid eliminating the element of causation in FCA litigation, Mr. Boese emphasizes that many courts have applied a heightened materiality concept without necessarily abandoning the "natural tendency" standard. *Id.* at 2-164 through 2-165.

Thus, for example, in *U.S. v. Southland Management Corp.*, 326 F.3d 669, 679-80 (5th Cir. 2003), Circuit Judge Jones, in a concurring opinion, written on behalf of four other circuit judges, pointed out that although the Fifth Circuit seemingly applies the natural tendency test for materiality, the determination for materiality should be "context-specific." As an example, Judge Jones characterizes the Ninth Circuit's decision in *United States ex rel. Hopper v. Anton*, 91 F.3d 1261, 1266 (9th Cir. 1996), as involving the situation in which the responsible government official did not even see or review the allegedly false certification in question in that case. She notes that in such a situation a false certification could not be deemed to be material for FCA liability purposes.[5]

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[5] Actual reliance has also been deemed to be a necessary component of the government's burden of proof in analogous situations, such as securities fraud cases. *See Dura Pharmaceutical v. Broudo*, 544 U.S. 336, 343-44 (2005) [if no reliance on the

(Continued on following page)

This is the precise situation here. The responsible government official, the Medicare fiscal intermediary, did not act or rely on the three cost reports in question, either with respect to processing them or adjusting interim payment rates based on them. While a Medicare regulation, 42 C.F.R. § 413.64(i), seemingly required the fiscal intermediary to use the cost reports to adjust interim payment rates, the fiscal intermediary did not in fact do so because of the Medicare Manual provision, PRM Section 2408.2 (App. at 85-86), which required the fiscal intermediary to put the cost reports "on hold" because the provider was bankrupt or insolvent.

While many courts deem reliance and causation factors to be part of the materiality issue, others analyze it as being relevant to the determination of damages. Thus, in *U.S. ex rel. Schwedt v. Planning Research Corp.*, 59 F.3d 196, 199-200 (D.C. Cir. 1995), the Court held that if an FCA plaintiff cannot prove that the government relied on a false claim or representation in making a payment decision, there will be no damages. However, the defendant would still be liable for civil penalties because of the submission of the false claims or representation. The Court in *Planning Research* further pointed out that it agreed with the Third and Fifth Circuits that damages must

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misinterpretation, then it is not actionable under the Securities laws].

be limited to those that arise from the false claims themselves.

Here, however, the Court of Appeals found the cost reports to be material because they potentially affected Bayview's interim rates but then imposed damages based on a calculation that had nothing to do with any potential adjustment to interim rates. Instead, it affirmed the government's "what if" calculation of the allowable costs in the cost reports, which had nothing to do with any adjustment to interim payment rates made throughout the years.

C. The Ninth Circuit's Decision Also Conflicts With Its Own Previous Decision and the Relevant Decisions of This Court Concerning the Excessive Fines Clause and the Due Process Clause

Notwithstanding expressly recognizing that an award of treble damages and civil penalties under the FCA is subject to review under the Eighth Amendment's excessive fines clause, as determined by the Ninth Circuit in *United States v. Mackby,* 339 F.3d 1013, 1016 (9th Cir. 2003), the Court of Appeals held here that it found no law requiring the District Court to award less than treble damages and the maximum amount of allowable civil penalties to satisfy the excessive fines clause. Court of Appeals opinion, App. at 32.

This conclusion is clearly inconsistent with *U.S. v. Mackby*, *supra*, where the Court of Appeals analyzed the District Court's Award of damages and civil penalties under the excessive fines clause even though they were far less than the maximum amounts that could have been ordered under the statute. In *Mackby*, the Ninth Circuit upheld a judgment of approximately $730,000 even though the maximum amount allowable under the FCA in that case was approximately $85,000,000 in civil penalties and $1,000,000 in treble damages.

Because it held that no law required an award of treble damages to be analyzed under the Eighth Amendment, the Court of Appeals did not analyze the respective culpability of each petitioner and did not consider such critical factors as the District Court's conclusions that none of the petitioners was unjustly enriched or defrauded the government.

The Ninth Circuit's holding that a court is not required to award less than maximum damages and penalties under the FCA regardless of the excessive fines clause effectively undoes its previous holding in *Mackby* acknowledging the applicability of the excessive fines clause to FCA judgments whether or not maximum penalties and treble damages are awarded. In *Mackby*, the Ninth Circuit concluded that the treble damages and civil penalties of the FCA were, at least in part, punitive and therefore subject to the excessive fines clause based on this Court's decision in *United States v. Bajakajian*, 524 U.S. 321 (1998). *See United States v. Mackby*, 261 F.3d 821, 830-31

(9th Cir. 2001). Nothing in *Bajakajian* or *Mackby* supports the conclusion that a District Court is prohibited from reducing a judgment below statutory limits based on the excessive fines clause.

Other courts have agreed with *United States v. Mackby*. *See,* for example, *Hays v. Hoffman,* 325 F.3d 982, 992 (8th Cir. 2003). Still, other courts have ignored *Mackby*. For example, in *U.S. v. Rogan,* 517 F.3d 449, 453 (7th Cir. 2008), the Seventh Circuit, without mentioning *Mackby*, held "it is far from clear that the Excessive Fines Clause applies to civil actions under the False Claims Act." According to the Seventh Circuit, the law is "unsettled," regarding this issue. *Id.* at 454. Rather than helping to settle the law in this area, the Ninth Circuit's decision leaves it further unsettled, which, most respectfully, requires this Court to act.[6]

In addition to raising issues under the Excessive Fines Clause, the amount of the judgment in this case also triggers due process concerns, which, although raised in the District Court and on appeal, were completely ignored by the Ninth Circuit in its opinion.

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[6] In *Browning-Ferris Industries, Inc. v. Kelco Disposal, Inc.*, 492 U.S. 257, 276 (1989), this Court noted that it had left open the question of whether the Eighth Amendment's excessive fines clause applies to judgments under the FCA. Most respectfully, this case presents the perfect opportunity to settle the question.

Once again, FCA commentator Boese points out that when the trebling provision of the FCA are applied to situations in which single damages are very high, they necessarily lose their remedial effect and any reasonable punitive effect. Under such circumstances, only a single multiplier can be considered reasonable for due process purposes. As pointed out above, this Court has supported this reasoning in other circumstances, especially when, as here, compensatory damages are substantial. *See State Farm Mutual Automobile Ins. Co. v. Campbell*, 538 U.S. at 429.

In essence, the Court of Appeals deferred to the District Court on the excessiveness issue under the mistaken legal impression that no law required the District Court to reduce damages and penalties below the statutory limits. Not only is this conclusion inconsistent with the case law discussed above, it also is inconsistent with this Court's ruling in *Cooper Industries v. Leatherman Tool,* 532 U.S. 436 (2001), reversing the Ninth Circuit because it did not make an independent determination of the relevant factors for determining excessiveness under the Constitution.

THE NINTH CIRCUIT'S DECISION IS PLAINLY WRONG

The Ninth Circuit's adoption of the natural tendency test for determining materiality allowed it to uphold the District Court's liability determination

under the FCA even though the false cost reports had no actual impact on any government payment decision and had not been relied on by the government. Nothing in the FCA suggests that false statements which are not relied on by the government are actionable under the FCA. The mere possibility that a false statement or false claim could be relied on by the government and could therefore potentially affect a payment determination has no textual support for imposing liability under the FCA.

The government will no doubt argue, as it argued below, that petitioners were obligated to submit checks to the Medicare fiscal intermediary along with the cost reports because the cost reports showed an amount owing to the Medicare program when filed.[7] This was, indeed, the case with each cost report even though each cost report contained false entries which lowered the amount owing.

Under the applicable Medicare Manual provision, PRM Section 2409.1.A.2 (App. at 103-105), the Medicare fiscal intermediary was required to make a demand for payment upon a provider which fails to submit payment with its cost report *unless* the provider was in bankruptcy or insolvent, which was the case here. Indeed, the Medicare fiscal intermediary

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[7] The Court of Appeals did not use this argument to support materiality or damages in its opinion. Rather, it spoke only of the potential impact on interim payment rates, which was never addressed at trial.

expressly acknowledged this fact in connection with the 1998 cost report. By letter dated November 17, 1999, it told Bayview (CPMS) that it was prohibited from making demands regarding any debt owing as a result of the filing of the cost report because of CPMS' bankruptcy. *See* Exhibit I, App. at 101-102.

In reality, the situation here is no different than it would have been if the fiscal intermediary had simply thrown the cost reports in the trash can. While such cost reports might contain false cost report entries, they would have had no impact on any payment decision by the government. The Court of Appeals' holding that the cost reports impeded the fiscal intermediary's ability to determine whether it should have decreased interim payments raises nothing more than a potential impact, one that did not actually occur. As indicated above, the cost reports, as filed, showed amounts owing by Bayview to the government and the fiscal intermediary knew Bayview was in bankruptcy or insolvent. Yet, it took no steps to adjust the interim payment rates, and instead, knowingly and deliberately chose to continue to pay Bayview at the interim payment rates determined by Bayview's 1996 Medicare cost report.

The Court of Appeals' opinion is also wrong because the government is not damaged if it does not rely on false representations. As emphasized above, the District Court found that the government failed to prove such reliance in this case. Yet, the District Court and the Court of Appeals concluded that the false representations somehow caused the government to

sustain actual damages. Under the case law established in the District of Columbia, *U.S. ex rel. Schwedt v. Planning Research Corp., supra,* damages are not warranted and the government is limited in such situations only to recovering civil penalties since the government did not prove it relied on the false representations.

In addition to being erroneous because the false cost reports were not material to a government payment decision and did not cause any damages, the Court of Appeals' decision is also wrong because the Court of Appeals did not analyze the amount of the judgment to determine whether it was grossly disproportional to the conduct of the petitioners and the loss purportedly suffered by the government. Rather, as pointed out above, the Court believed such an analysis was not required under the "law" so long as the judgment did not exceed the maximum amount of the penalties and did not exceed treble damages. This "reasoning" effectively means that an FCA judgment may not be scrutinized under the excessive fines clause unless a trial court issues a judgment in excess of the maximum limits permitted under the statute. However, in such a situation, the judgment would violate the statute and would not require analysis under the Constitution.

By definition, the excessive fines clause and the due process clause analysis necessarily are applicable in those situations in which the District Court has acted *within* the limits of the statute but has awarded a judgment which is nevertheless grossly

disproportional to the conduct of the defendant and the loss incurred by the government. The Court of Appeals did not perform that analysis here. Thus, among the important factors ignored by the Ninth Circuit in upholding the amount of the judgment are:

1. The relative culpability of the respective individual petitioners;

2. The fact that the District Court found the government failed to prove common law fraud on the part of any of the petitioners;

3. The fact that the District Court concluded that none of the petitioners had been unjustly enriched; and

4. The fact that the government did not have to share any portion of the judgment with a *qui tam* relator, which is one reason why the statute was amended in 1986 to raise the damages provision from double damages to treble damages (*see Cook County Ill. v. U.S. ex rel. Chandler,* 538 U.S. at 131-32).

The analysis is thus very different from the analysis employed by the Ninth Circuit in *United States v. Mackby,* where the Court carefully analyzed several different factors, including the fact that the judgment awarded in that case was far less than the maximum amount allowed under the FCA. Here, the opposite is true. The Court affirmed the maximum amount of recovery without regard to the factors discussed above and others.

CONCLUSION

The Court is respectfully requested to grant this petition to resolve the important questions presented.

DATED: October 23, 2008

Respectfully submitted,

HOOPER, LUNDY & BOOKMAN, INC.
PATRIC HOOPER
Attorneys for Petitioners

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA, *Plaintiff-Appellee*, v. ROBERT I. BOURSEAU; RIB MEDICAL MANAGEMENT SERVICES, INC., a California corporation, *Defendants-Appellants*, and RUDRA SABARATNAM; NAVATKUDA, INC., a California corporation, *Defendants*.	No. 06-56741 D.C. No. CV-03-00907-RTB
UNITED STATES OF AMERICA, *Plaintiff-Appellee*, v. ROBERT I. BOURSEAU; RIB MEDICAL MANAGEMENT SERVICES, INC., a California corporation, *Defendants*, and RUDRA SABARATNAM; NAVATKUDA, INC., a California corporation, *Defendants-Appellants*.	No. 06-56743 D.C. No. CV-03-00907-RTB OPINION

Appeal from the United States District Court
for the Southern District of California
Roger T. Benitez, District Judge, Presiding

Argued and Submitted
April 9, 2008 – Pasadena, California

Filed July 14, 2008

Before: Robert R. Beezer, Cynthia Holcomb Hall, and Barry G. Silverman, Circuit Judges.

Opinion by Judge Beezer

COUNSEL

Patric Hooper, Los Angeles, California, for appellants Robert I. Bourseau and RIB Medicial Management Services, Inc.

Patric Hooper and Howard S. Levine, Los Angeles, California, for appellants Rudra Sabaratnam and Navatkuda, Inc.

Peter D. Keisler, Assistant Attorney General, Karen Hewitt, Acting United States Attorney, and Douglas Letter and Robert J. McAuliffe, Assistant United States Attorneys, Washington, D.C., for the appellee.

OPINION

BEEZER, Circuit Judge:

Robert I. Bourseau ("Bourseau"), RIB Medical Management Services, Inc. ("RIB"), Dr. Rudra Sabaratnam ("Sabaratnam") and Navatkuda, Inc.

("Navatkuda") (collectively, "Appellants"), appeal the district court's judgment holding them jointly and severally liable to the United States ("government") for violations of the False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733. We affirm.

I

The parties agree that the underlying facts are not in dispute. The government brought this case on behalf of the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services ("Medicare") against two psychiatric hospital operators, Bourseau and Sabaratnam, and their single-employee corporations, RIB and Navatkuda, for fraud in the context of the Medicare reimbursement process.

A. The Medicare Reimbursement Process

Medicare reimburses hospitals, including psychiatric hospitals, for the reasonable costs of services that the hospitals provide to Medicare beneficiaries. 42 U.S.C. §§ 1395d(c), 1395k, 1395x(v)(1)(A); 42 C.F.R. § 410.27. Medicare reimburses such providers only for the portion of costs that relate to Medicare patients. 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 413.50. Medicare contracts with private insurance companies, known as fiscal intermediaries, to facilitate the reimbursement process. 42 U.S.C. § 1395h; 42 C.F.R. § 413.64. Intermediaries pay providers an interim amount periodically throughout the year that

is based on estimated treatment costs for Medicare patients. 42 U.S.C. § 1395g(e); 42 C.F.R. §§ 413.60, 413.64. At the end of the year, providers submit a final accounting of their actual costs for the year to their intermediaries in a document called a cost report. 42 C.F.R. § 413.20.

In order to reimburse providers for their Medicare expenses as quickly as possible, intermediaries make an initial retroactive adjustment to the interim payments as soon as they receive the providers' cost reports. 42 C.F.R. § 413.64(f)(2); Provider Reimbursement Manual ("PRM"), Pt. 1 § 2408.2. In making the initial retroactive adjustment, intermediaries accept costs as they are reported on a cost report, except for obvious errors and inconsistencies. 42 C.F.R. § 413.64(f)(2); PRM, Pt. 1 § 2408.2. The cost reports are later subject to an audit. 42 C.F.R. § 413.64(f)(2); PRM, Pt. 1 § 2408.2. After intermediaries audit a cost report, intermediaries determine the providers' and Medicare's final liability to one another. 42 C.F.R. § 413.64(f)(2); PRM, Pt. 1 § 2408.2. In other words, an intermediary will use a cost report to determine whether a provider, or Medicare, is owed money based on the difference between the interim payments already paid to the provider and the actual amount that the intermediary determines was actually due to the provider. 42 C.F.R. §§ 405.1803, 413.9(b)(1), 413.60, 413.64(f). Recoupment of any overpayments made to a provider is made notwithstanding any request for a hearing to review an intermediary's determination. 42 C.F.R. § 405.1803(c).

If an intermediary has a valid basis for believing that proceedings have been or will be instituted in state or federal court to determine the solvency of a provider, the intermediary will adjust any interim payments "notwithstanding any other regulation or program instruction regarding the timing or manner of such adjustments, to a level necessary to insure that no overpayment to the provider is made." 42 C.F.R. § 413.64(i).

B. Appellants' Cost Reports for 1997, 1998 and 1999

Between 1994 and 2000, Bayview Hospital and Mental Health Systems ("Bayview") was a psychiatric hospital that participated in the Medicare program. Bayview was owned and operated by a California limited partnership, known as California Psychiatric Management Services ("CPMS"). The only general partners in CPMS were RIB and Navatkuda. Bourseau controlled RIB and served as its president and sole employee. Sabaratnam controlled Navatkuda and served as its president and sole full-time employee. Bourseau and Sabaratnam, through RIB and Navatkuda, ran CPMS and Bayview. Bourseau focused on operations management while Sabaratnam focused on medical management.

In 1996, CPMS filed for Chapter 11 bankruptcy. In 1998, the United States Bankruptcy Court for the Central District of California approved a reorganization plan for CPMS which, among other things, gave

National Century Financial Enterprises, Inc. ("NCFE") a 49.9% limited partnership interested in CPMS. This made NCFE and CPMS "related parties" as that term is defined in the Medicare regulations.

Between 1997 and 1999, CPMS retained Paul Fayollat ("Fayollat") and Loretta Masi ("Masi") of Pacific Hospital Management to prepare and submit Bayview's 1997, 1998 and 1999 cost reports to its intermediary, Mutual of Omaha Insurance Company ("Mutual of Omaha").

In preparing the 1997 cost report, Bourseau and Sabaratnam met with Fayollat, Masi and CPMS' Director of Finance, Seth Morriss ("Morriss"). Fayollat advised Bourseau that Medicare would not reimburse Bayview for interest and bankruptcy legal fees unrelated to Bayview's Medicare patient services, and that it would be improper to include such amounts in the cost report. Notwithstanding Fayollat's advice, Bourseau directed Fayollat to include in the 1997 report (1) the total amount of interest charged by NCFE for earlier loans and (2) all of CPMS' bankruptcy legal fees. Only a portion of the interest and bankruptcy legal fees related to the operation of Bayview. CPMS never paid the interest to NCFE.

In preparing the 1998 cost report, Bourseau and Sabaratnam again met with Fayollat, Masi and Morriss. Fayollat advised Bourseau that Medicare would not reimburse Bayview for interest and bankruptcy legal fees unrelated to Bayview's Medicare patient services, and that it would be improper to

include such amounts in the cost report. Notwithstanding Fayollat's advice, Bourseau directed Fayollat to include in the 1998 cost report (1) the total amount of interest charged by NCFE, (2) all of CPMS' bankruptcy legal fees, (3) a rental expense for a lease that never existed, (4) 16,965 additional square feet of space for a partial hospitalization program, although little of the additional space was actually used for Medicare patient care or operation support and (5) management fees for NCFE. Only a portion of the interest and bankruptcy legal fees related to the operation of Bayview. CPMS never paid the interest to NCFE.

In preparing the 1999 cost report, Bourseau again ignored Fayollat's advice and directed that Fayollat include in the 1999 cost report (1) all of CPMS' bankruptcy legal fees, (2) 16,965 additional square feet of space for the partial hospitalization program, although little of the additional space was actually used for patient care, (3) management fees for NCFE and (4) "program costs," representing additional interest payable to NCFE. CPMS never paid the interest to NCFE.

Mutual of Omaha never made adjustments to Bayview's cost reports, never audited the cost reports and never collected overpayments or paid underpayments. Between July of 1997 and October 2000, Bayview's Medicare reimbursement rates did not change. And in 2000, CPMS filed for bankruptcy again.

The government filed suit against Appellants in the United States District Court for the Southern District of California, alleging (1) violations of the FCA, (2) unjust enrichment and (3) common law fraud. After a six day bench trial, the district court held Appellants jointly and severally liable to the government for the FCA claims only. The district court found that Appellants' 1997, 1998 and 1999 cost reports constituted false claims under the FCA, actionable as both affirmative false claims and reverse false claims. The district court found that by including false costs in its cost reports, Bayview had decreased the amount it owed Medicare by $5,219,195. The district court awarded the government $15,657,585 in treble damages and $31,000 in civil penalties.

Appellants timely and separately appealed. We consolidated their appeals.

II

The district court had jurisdiction to enter its judgment despite CPMS' bankruptcy proceedings in 2000. *See* 11 U.S.C. § 362(b)(4); 28 U.S.C. § 1345; 31 U.S.C. § 3732(a); *Universal Life Church v. United States,* 128 F.3d 1294, 1298 (9th Cir. 1997). We have jurisdiction over this appeal under 28 U.S.C. § 1291.

We review de novo mixed questions of law and fact, *Mathews v. Chevron Corp.,* 362 F.3d 1172, 1180 (9th Cir. 2004), and a district court's interpretation of the FCA, *U.S. ex rel. Sequoia Orange Co. v.*

Baird-Neece Packing Corp., 151 F.3d 1139, 1143 (9th Cir. 1998). We review for clear error a district court's underlying factual findings, a standard which is "significantly deferential, requiring a 'definite and firm conviction that a mistake has been committed' before reversal is warranted." *Mathews*, 362 F.3d at 1180 (internal quotation omitted).

III

Appellants argue that their 1997, 1998 and 1999 cost reports do not violate the reverse false claims provision of the FCA.[1] We disagree.

Title 31 U.S.C. § 3729(a)(7), the reverse false claims provision of the FCA, punishes anyone who "knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government." The government must prove five elements in order to establish liability

[1] Appellants also argue that their cost reports are not actionable as affirmative false claims because the cost reports are not "claims" for payment. This argument has been squarely rejected. *See United States v. Neifert-White*, 390 U.S. 228, 233 (1968); *United States v. Jackson*, 845 F.2d 880, 882-83 & n.6 (9th Cir. 1988); S. Rep. No. 99-345, at 18-19 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 5266, 5283-84. Nevertheless, we need not analyze Appellants' liability under the affirmative false claims provisions of the FCA because we hold that the government has established liability under the reverse false claims provision.

under § 3729(a)(7). In this case, the government has met its burden.

A. False Record or Statement

Appellants do not contest that the cost reports are records or statements submitted to a government agent, but argue that none of the claimed costs is false.

The FCA does not define false. Rather, courts decide whether a claim is false or fraudulent by determining whether a defendant's representations are accurate in light of applicable law. *U.S. ex rel. Oliver v. Parsons Co.,* 195 F.3d 457, 463 (9th Cir. 1999). Applicable law is subject to judicial interpretation.[2] *Id.* Courts have interpreted the FCA to cover claims for services not rendered, *see United States v. Kitsap Physicians Serv.,* 314 F.3d 995, 1002 (9th Cir. 2002), and Medicare cost reports containing nonallowed or inflated costs, *see, e.g., United States v. Halper,* 490 U.S. 435, 437 (1989), *overruled on other grounds by Hudson v. United States,* 522 U.S. 93

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[2] Appellants argue that their statements were not false under a reasonable interpretation of the applicable regulations. Some courts hold that the government must prove that a claim is false under any reasonable interpretation of applicable law to succeed under the FCA. *See, e.g., United States v. Alder,* 623 F.2d 1287, 1289 (8th Cir. 1980). We reject this approach. *See Parsons,* 195 F.3d at 463 (holding that the reasonableness of an interpretation may be relevant to the knowledge requirement but not the falsity requirement).

(1997) (discussing damages resulting from inflated costs); *U.S. ex rel. A+ Homecare, Inc. v. Medshares Mgmt. Group, Inc.*, 400 F.3d 428, 451 (6th Cir. 2005) (unpaid costs); *Shaw v. AAA Eng'g & Drafting, Inc.*, 213 F.3d 519, 530 (10th Cir. 2000) (nonallowed costs).

Each of the claimed costs identified by the government is false as that term is used in the FCA context, for the reasons set forth below.

1. Interest

The claims for interest were false for several reasons. First, the district court found, and Appellants do not dispute, that CPMS never paid any interest to NCFE. Under the Medicare regulations, interest must be paid within one year after it is included in a cost report unless "the provider furnishes to the intermediary sufficient written justification (based upon documented evidence) for nonpayment of the liability" and the intermediary grants an extension for good cause. 42 C.F.R. § 413.100(c). In this case, Mutual of Omaha knew that CPMS was in bankruptcy before March 1998 and after June 2000,[3] but CPMS never provided written justification based upon documented evidence for why it could not pay the interest to NCFE within one year, nor asked Mutual of Omaha for an extension for good

[3] This knowledge would still not excuse including the interest on the 1999 and much of the 1998 reports, because CPMS was not in bankruptcy at those times.

cause. Nonpayment of the interest under these circumstances renders the claimed interest nonallowable and false.

Second, the district court found that the 1997 and 1998 cost reports inflated the amount of interest related to Medicare patients. This finding is not clearly erroneous. Bourseau admitted that much of the claimed interest did not relate to Medicare patient care at Bayview. Medicare only reimburses providers for expenses related to the care of Medicare beneficiaries. 42 U.S.C. § 1395f(b); 42 C.F.R. § 413.9. In the event that an intermediary deems a cost nonallowable but the provider disagrees, the provider may still include the cost in a cost report if "[t]he provider clearly indicates [the] item(s) is being included in the cost report only to establish the basis for an appeal and each disputed item and amount is specifically identified." PRM, Pt. 1 § 2905.2. "When [a provider files] a cost report under protest, the disputed item and amount for each issue must be specifically identified in footnotes to the settlement worksheet and the fact that the cost report is filed under protest must be disclosed." PRM, Pt. 2 § 115.1. "In addition, [a provider] must submit, with the cost report, copies of the working papers used to develop the estimated adjustments in order for the intermediary to evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable." PRM, Pt. 2 § 115.2.

In a cover letter accompanying its 1997 cost report, CPMS put Mutual of Omaha on notice that it

intended to include interest as a disputed item in the cost report, and that it would include supporting workpapers and documentation. The cost report contains an entry for the interest, but does not clearly indicate that the interest is a disputed item. Appellants do not provide supporting workpapers and there are no footnotes or other explanatory materials.

Similarly, in a cover letter accompanying its 1998 cost report, CPMS put Mutual of Omaha on notice that it intended to include interest as a disputed item in the cost report and that it would include supporting workpapers and documentation. The letter does not indicate where to find the item in the cost report, and there are no footnotes or other explanatory materials. The interest claimed in the 1997 and 1998 reports was inflated and did not comply with regulations governing disputed items, rendering the claimed interest false.

Third, the district court found that CPMS and NCFE were related parties. This finding is not clearly erroneous because NCFE had a 49.9% limited partnership interest in CPMS. *See* 42 C.F.R. §§ 413.17(a), (b). Interest is not reimbursable if paid to a lender that is related to the provider through control or ownership, with limited exceptions that do not apply here. *See* 42 C.F.R. §§ 413.153(b)(3)(ii), (c). CPMS' inclusion of the nonallowable interest renders the claimed interest false.

Finally, the district court found that the interest claimed in 1997, 1998 and 1999 cost reports was not

supported by adequate documentation. This finding is not clearly erroneous because Appellants cannot cite any documentation to support the interest expenses. Medicare requires that providers include adequate cost data to support their claims for reimbursement. 42 C.F.R. §§ 413.20(a), (d), 413.24(a). CPMS' failure to adequately document the interest in these circumstances renders the claimed interest false.

2. Bankruptcy Legal Fees

The claims for bankruptcy legal fees were false. The district court found, and CPMS does not dispute, that the amount of bankruptcy legal fees claimed exceeded the amount of fees related to Bayview and/or Medicare patient care at Bayview. "Legal fees and related costs incurred by a provider are allowable if related to the provider's furnishing of patient care, e.g., legal fees incurred in appeals to the Provider Reimbursement Review Board. . . ." PRM, Pt. 1 § 2183. Appellants' inclusion of legal fees unrelated to patient care or Bayview renders the claimed bankruptcy legal fees false.

Bourseau's argument that the fees were properly included as disputed items fails because the cost report cover letters do not indicate where to find the fees in the cost reports and Appellants do not provide supporting workpapers, footnotes or other explanatory materials. *See* 42 C.F.R. §§ 413.20(a), (d), 413.24(a); PRM, Pt. 2 § 115.2.

3. Additional Space

The claims for additional space were false. The additional space was used for staff meetings and storage, rather than patient care. Medicare allows reimbursement for areas used for staff meetings and storage, but it is allowable only in the "administrative and general" area of a cost report, not the "partial hospitalization program" area. Tr. 498:13-18; 793:4-794:23; 943:5-944:12. CPMS included the additional space in the wrong area of the cost report, which inflated the amount of CPMS' actual allowable costs. Under these circumstances, the claimed additional space was false.

4. Management Fees

The claims for management fees paid to NCFE were false. The district court found that NCFE provided no management services to CPMS. This finding is not clearly erroneous. The only evidence that NCFE provided management services was Bourseau's trial testimony that NCFE sent a representative to Bayview once per quarter to work with the accounting firm. At a pretrial deposition, Bourseau could not describe NCFE's management services in any detail, even though NCFE received payments of $20,000 per month for management services. Medicare reimburses management fees only to the extent they are incurred for the efficient delivery of needed health services to Medicare beneficiaries. 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 413.9(a). Under these

circumstances, the claimed management fees were false.

5. Rental Expense

Finally, the claimed rental expense was false. Appellants admit that the rental expense never existed.

B. Knowledge of Falsity

Bourseau argues that he did not knowingly include false statements in the cost reports because he relied on good faith interpretations of the Medicare regulations in submitting the cost reports. Sabaratnam argues that he did not knowingly include false statements in the cost reports because financial operations were not his responsibility.

The FCA defines "knowing" and "knowingly" to mean that, with respect to information, a person: "(1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information." 31 U.S.C. § 3729(b). "[N]o proof of specific intent to defraud is required." *Id.* "'The requisite intent is the knowing presentation of what is known to be false,' as opposed to innocent mistake or mere negligence. 'Bad math is no fraud,' proof of mistakes 'is not evidence that one is a cheat,' and 'the common failings of engineers and other scientists are not culpable under the Act.'"

Hagood v. Sonoma County Water Agency, 81 F.3d 1465, 1478 (9th Cir. 1996) (quoting *U.S. ex rel. Anderson v. N. Telecomm., Inc.,* 52 F.3d 810, 815 (9th Cir. 1995)).

1. Bourseau and RIB

Bourseau acted with knowledge that each disputed item in the cost report was false.

Bourseau acted with actual knowledge that the claimed interest was false. He admitted that it had never been paid, yet did not provide written justification or request an excuse for nonpayment, *see* 42 C.F.R. § 413.100(c), did not disclose it as a disputed item with any detail near that required, *see* PRM, Pt. 1 § 2905.2; PRM, Pt. 2 § 115, and did not retain adequate supporting documentation, *see* 42 C.F.R. §§ 413.20(a), (d), 413.24(a).

Bourseau acted with at least reckless disregard of the truth or falsity of the claimed bankruptcy legal fees. He admitted that much of the bankruptcy legal fees did not relate to Medicare patient care, even though it is clear that reimbursable fees must relate to patient care. PRM, Pt. § 2183. He also failed to disclose the fees as a disputed item with any detail near that required. PRM, Pt. 1 § 2905.2; PRM, Pt. 2 § 115.

Bourseau acted with at least reckless disregard of the truth or falsity of the additional space. Medicare allows reimbursement for meeting and storage

space,[4] but CPMS included it in the wrong area of the report, resulting in a higher reimbursement to CPMS.

Bourseau acted with actual knowledge that the management fees were false. The district court properly found that NCFE never rendered management fees, which Bourseau would have known based upon his position within CPMS.

Finally, Bourseau acted with at least reckless disregard of the truth or falsity of the rental expense. Bourseau admitted that the rental expense never existed, but claims that its inclusion in the cost report was a mistake. Affirmatively including a non-existent rental expense of $396,209 on a cost report to seek reimbursement from the government is at least reckless disregard of the truth or falsity of the rental expense, if not actual knowledge of the falsity of the rental expense.

Considering the regulations described above and the degree to which Bourseau's actions deviated from them, Bourseau did not rely on good faith interpretations of the regulations in including the disputed costs in the cost reports. *Cf. Parsons*, 195 F.3d at 463 (recognizing that a good faith but mistaken interpretation of applicable regulations may negate the knowledge requirement).

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[4] There is evidence to suggest that this space had actually been closed for years. Tr. 613:2-13.

2. Sabaratnam and Navatkuda

The district court found that Sabaratnam agreed with Bourseau's decision to submit the cost reports. This finding is not clearly erroneous. Although Sabaratnam did not prepare or sign the cost reports, he was generally familiar with cost reports, having signed one in the past, and he had attended two meetings held for the purpose of discussing the cost reports at issue. In addition, when asked whether Sabaratnam agreed with Bourseau's 1998 cost reporting decisions, Bourseau responded, "I would say so, but it just wasn't his area of responsibility, it was mine." Tr. 1000:14-21. Sabaratnam acted with at least reckless disregard to the truth or falsity of each claim when he agreed to submit the cost reports.

Notwithstanding his agreement with Bourseau, Sabaratnam also acted in deliberate ignorance of the truth of the cost reports. In defining knowingly, Congress attempted "to reach what has become known as the 'ostrich' type situation where an individual has 'buried his head in the sand' and failed to make simple inquiries which would alert him that false claims are being submitted." S. Rep. No. 99-345, at 21 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 5266, 5286. Congress adopted "the concept that individuals and contractors receiving public funds have some duty to make a limited inquiry so as to be reasonably certain they are entitled to the money they seek." *Id.* at 20; *see also id.* at 7 (discussing the importance of individual responsibility because the government has

limited resources to police fraud). "While the Committee intends that at least some inquiry be made, the inquiry need only be 'reasonable and prudent under the circumstances.'" *Id.* at 21.

Sabaratnam, as president of Navatkuda and a general partner of CPMS, depended upon the cost reports for reimbursement just as much as Bourseau and RIB. He undertook no inquiry into the cost reports, let alone a reasonable and prudent one. His behavior falls within the category of deliberate ignorance.

Sabaratnam and Navatkuda, along with Bourseau and RIB, acted with the scienter required under the FCA.

C. Makes, Uses or Causes to be Made or Used a False Statement

Sabaratnam argues that he did not make, use or cause to be made or used the cost reports at issue.[5]

Sabaratnam frames his argument solely in terms of "presentment," arguing that he did not "present or cause to be presented" false claims to the intermediary. Presentment is an element in a cause of action under § 3729(a)(1), which punishes someone who "knowingly *presents, or causes to be presented,* to an

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[5] Bourseau does not dispute that he made, used and signed the cost reports at issue.

officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval." 31 U.S.C. § 3729(a)(1) (emphasis added). Presentment is not an element in a cause of action under § 3729(a)(7), which is the cause of action at issue here. *Cf. Allison Engine Co., Inc. v. U.S. ex rel. Sanders,* No. 07-214, slip op. at 6 (U.S. June 9, 2008) (holding that there is no presentment requirement in § 3729(a)(2), which uses the same "makes, uses, or causes to be made or used" language found in § 3729(a)(7)).

Unlike § 3729(a)(1), § 3729(a)(7) focuses on a defendant who "knowingly *makes, uses, or causes to be made or used,* a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government." 31 U.S.C. § 3729(a)(7) (emphasis added). The plain language of this statute requires that a defendant make or use a false record or statement in order to conceal, avoid or decrease an obligation to pay the government. *Cf. Allison Engine Co., Inc.,* No. 07-214, slip op. at 5 (holding that § 3729(a)(2) requires the government to prove that the defendant made a false statement to get a false claim paid or approved). Sabaratnam, in his capacity as president of Navatkuda and general partner of CPMS, used and agreed to use the false cost reports in order to decrease CPMS/Bayview's obligation to pay money to Medicare.

D. Purpose to Conceal, Avoid or Decrease an Obligation to Pay Money to the Government

Appellants argue that they had no specific, independent, preexisting obligation to pay Medicare. Appellants argue that their interim payment rates were based upon the cost report from 1996, such that any repayment obligation arose because of the 1996 cost report. Appellants further argue that they had no duty to pay a "specific and definite sum" because the cost reports were never audited.

The FCA does not define "obligation," and we have not set forth a framework for determining whether an obligation exists under the FCA. The Sixth and Eighth Circuits use the following analysis in determining whether an obligation exists:

> To recover under the False Claims Act, . . . the United States must demonstrate that it was owed a specific, legal obligation at the time that the alleged false record or statement was made, used, or caused to be made or used. The obligation cannot be merely a potential liability: instead, in order to be subject to the penalties of the False Claims Act, a defendant must have had a present duty to pay money or property that was created by a statute, regulation, contract, judgment, or acknowledgment of indebtedness. The duty, in other words, must have been an obligation in the nature of those that gave rise to actions of debt at common law for money or things owed. . . . The deliberate use of the

> certain, indicative, past tense suggests that Congress intended the reverse false claims provision to apply only to existing legal duties to pay or deliver property.

Am. Textile Mfrs. Inst., Inc. v. The Ltd., Inc., 190 F.3d 729, 735 (6th Cir. 1999) (quoting *United States v. Q Int'l Courier, Inc.*, 131 F.3d 770, 773 (8th Cir. 1997)).

This definition is consistent with the language and intent of the FCA, *see* S. Rep. No. 99-345, at 9 ("A false claim for reimbursement under the Medicare, Medicaid or similar program is actionable under the act. . . ."), as well as holdings of the Fifth, Tenth and Eleventh Circuits. *See U.S. ex rel. Bahrani v. Conagra, Inc.*, 465 F.3d 1189, 1195-96 (10th Cir. 2006), *cert. denied*, 128 S. Ct. 388 (2007) (holding that an obligation must be existing and arise from an independent legal duty); *U.S. ex rel. Bain v. Ga. Gulf Corp.*, 386 F.3d 648, 657 (5th Cir. 2004) (defining what an obligation is not); *United States v. Pemco Aeroplex, Inc.*, 195 F.3d 1234, 1237 (11th Cir. 1999) (recognizing an obligation exists pursuant to contract). We adopt it.

Under this framework, Appellants had a legal obligation to pay the government money at the time they submitted the cost reports. Between 1994 and 2000, CPMS was a Medicare provider, subject to a Medicare Provider Agreement requiring compliance with all Medicare regulations. *See* 42 U.S.C. § 1395cc; 42 C.F.R. §§ 411.406, 413.24(f), 489.11. Medicare regulations allowed CPMS to receive interim

payments throughout the year from the Medicare Trust Fund, but required that CPMS repay any overpayments at the end of each reporting period. 42 C.F.R. § 413.20(d)(1); *see also* 42 U.S.C. § 1395g(a); 42 C.F.R. §§ 413.60, 413.64, 405.377, 405.378, 405.1803. Medicare was also required to pay CPMS any underpayments at the end of each reporting period. 42 C.F.R. § 413.20(d)(1); *see also* 42 U.S.C. § 1395g(a); 42 C.F.R. §§ 413.60, 413.64, 405.377, 405.378, 405.1803.

Because cost reports are not final until after an audit, the specific amount of the repayment obligation, for either CPMS or Medicare, may not have been known at the time the report was filed, *see, e.g.,* 42 C.F.R. § 413.64(f), but both sides were under a continuing, specific obligation to repay each other. *See* S. Rep. No. 99-345, at 18-19 ("A false claim for reimbursement under [ ] Medicare . . . is actionable under the act."). Similarly, CPMS' bankruptcy may have frozen both the rate for interim payments and Medicare's ability to collect overpayments, but it did not eliminate CPMS' obligation to reimburse Medicare for overpayments. This obligation was not potential, like fines and penalties which have not been levied or assessed, but rather existing and specific because CPMS had been accepting Medicare funds. *See Ga. Gulf Co.,* 386 F.3d at 657-58.

By including nonexistent, nonallowed and inflated costs in their cost reports, Appellants concealed and decreased amounts that they were obligated to repay to Medicare. This obligation was fixed, even if

the specific amount of the repayment obligation was not.

E. Materiality

Appellants argue that their cost report entries were not material because they had no impact on any payment decision made by the intermediary.

The text of the FCA does not include a materiality requirement, but legislative history indicates that § 3729(a)(7) was enacted to provide that "an individual who makes a *material misrepresentation* to avoid paying money owed the Government should be equally liable under the Act as if he had submitted a false claim" S. Rep. No. 99-345, at 15 (emphasis added). We have incorporated a materiality element into the FCA, at least within the context of false certification and promissory fraud cases. *See U.S. ex rel. Hendow v. Univ. of Phoenix,* 461 F.3d 1166, 1174 (9th Cir. 2006), *cert. denied,* 127 S. Ct. 2099 (2007). Recently, the Sixth Circuit analyzed this issue and, using the framework set forth in *United States v. Wells,* 519 U.S. 482, 490-92 (1997), concluded that the FCA includes a materiality element. *Medshares Mgmt. Group, Inc.,* 400 F.3d at 440-44. We find the reasoning of the Sixth Circuit persuasive, and hold that the FCA includes a materiality requirement. This holding is consistent with the law in the First, Fourth, Fifth, Sixth and Eighth Circuits. *Medshares Mgmt. Group,* 400 F.3d at 442; *United States v. Southland Mgmt. Corp.,* 326 F.3d 669, 679 (5th Cir.

2003); *U.S. ex rel. Costner v. United States,* 317 F.3d 883, 886-87 (8th Cir. 2003); *U.S. ex rel. Berge v. Bd. of Trs. of the Univ. of Ala.,* 104 F.3d 1453, 1459 (4th Cir. 1997); *United States. v. Data Translation, Inc.,* 984 F.2d 1256, 1267 (1st Cir. 1992). *But see U.S. ex rel. Cantekin v. Univ. of Pittsburgh,* 192 F.3d 402, 415 (3d Cir. 1999) (casting doubt on whether materiality is an element under the FCA, but declining to resolve the issue).

The Supreme Court has stated that "[i]n general, a false statement is material if it has 'a natural tendency to influence, or [is] capable of influencing, the decision of the decisionmaking body to which it was addressed.'" *Neder v. United States,* 527 U.S. 1, 16 (1999). Yet, circuit courts are split on how to measure materiality in the context of the FCA. *See Medshares Mgmt. Group, Inc.,* 400 F.3d at 445. The Fourth and Sixth Circuits have adopted a "natural tendency test" for materiality, which focuses on the potential effect of the false statement when it is made rather than on the false statement's actual effect after it is discovered. *Id.* The Eighth Circuit has adopted a more restrictive "outcome materiality test," which requires a showing that the defendant's actions (1) had "the purpose and effect of causing the United States to pay out money it is not obligated to pay," or (2) "intentionally deprive[d] the United States of money it is lawfully due." *Id.* (citing *Costner v. URS Consultants,* 153 F.3d 667, 677 (8th Cir. 1998)). We agree with the Fourth and Sixth Circuits that the natural tendency test is the appropriate measure for

materiality because it is more consistent with the plain meaning of the FCA. *Id.* Applying the natural tendency test to this case, we hold that Appellants' cost report entries were material because they had the potential effect, or natural tendency, to decrease the amount CPMS owed Medicare in overpayments, despite the fact that cost reports were never audited.

Appellants' submission of the 1997, 1998 and 1999 cost reports satisfy all five elements necessary to establish liability under § 3729(a)(7).

IV

Appellants argue that the district court erred in awarding treble damages in this case. We disagree.

A. The Government Sustained Damages

Appellants argue that even if they are liable under § 3729(a)(7), the government did not sustain damages in this case because the government never relied upon the cost reports to pay CPMS.

Because of CPMS' 1996 bankruptcy, it is accurate to state that Medicare did not increase its rates beyond those set in the 1996 cost report. But Medicare was never prohibited from decreasing its rates, thereby minimizing any potential overpayments. If an intermediary has a valid basis for believing that proceedings have been or will be instituted in state or federal court to determine the solvency of a provider, the intermediary will adjust any interim payments

"notwithstanding any other regulation or program instruction regarding the *timing* or *manner* of such adjustments, *to a level necessary to insure that no overpayment to the provider is made.*" 42 C.F.R. § 413.64(i) (emphasis added). Although the Provider Reimbursement Manual may indicate that intermediaries will not make adjustments once they learn that a provider is potentially insolvent, by its very terms, section 413.64(i) applies regardless of the Provider Reimbursement Manual with respect to this issue. *Compare* 42 C.F.R. § 413.64(i), *with* PRM, Pt. 1 § 2408.2 (stating that intermediaries should not make a tentative or initial retroactive adjustment to interim payments when they know that a provider is insolvent, but rather that intermediaries should make necessary adjustments when the cost report is "settled."). Similarly, although the regulations provide that intermediaries generally do not determine final liability until after an audit is made, *see* 42 C.F.R. § 413.64(f)(2); PRM, Pt. 1 § 2408.2, section 413.64(i) clearly indicates that this general rule is preempted once an intermediary learns that a provider is potentially insolvent.

Appellants' inclusion of nonallowable, inflated and fictitious costs in the 1997, 1998 and 1999 cost reports impeded the intermediary's ability to determine whether maintaining the 1996 rates would result in overpayments, and therefore impeded the intermediary's ability to determine whether it should have decreased interim payments. This damaged the Medicare Trust Fund by causing Medicare to continue

making interim payments at the 1996 rates instead of lower rates.

The Sixth Circuit considered and rejected an argument similar to that made by Appellants. In *Medshares Management Group, Inc.*, the Sixth Circuit held that the government's failure to issue a notice of provider reimbursement ("NPR") does not preclude the government from establishing that it has sustained actual damages. 400 F.3d at 455. Instead, an NPR, which is a written document issued by the intermediary to the provider reflecting the amount of reimbursement due to the provider, is merely an administrative mechanism used to make adjustments for overpayments or underpayments. *Id.* at 456. Whether and when the intermediary issues an NPR does not change whether the government sustained damages to the treasury and to the integrity of the Medicare program as a result of fraud. *See id.* at 456-57.

CPMS owes Medicare money as a result of overpayments that Medicare made to CPMS based on the 1997, 1998 and 1999 cost reports. It now appears as though Medicare will not recover the full amount that it has already made in overpayments because CPMS has filed for bankruptcy again. Nonetheless, Medicare should be allowed to attempt to recover its losses in CPMS' bankruptcy. To hold otherwise would allow CPMS to escape repaying what it has already received in overpayments.

Damages for a reverse false claim consist of the difference between what the defendant should have paid the government and what the defendant actually paid the government. 1 John T. Boese, Civil False Claims and Qui Tam Actions 3-5 (3d ed. Supp. 2008). Once a defendant is found liable under any provision of § 3729(a), that defendant "is liable to the United States Government for . . . 3 times the amount of damages which the Government sustains because of the act." 31 U.S.C. § 3729(a). If the defendant cooperates with the government, then the defendant is liable to the government for "not less than 2 times the amount of damages which the Government sustains because of the act." *Id.*

In this case, the government's expert, Charles Potter ("Potter"), used a program to determine that Medicare overpaid CPMS by $5,219,195 between 1997 and 1999 because of the false claimed costs. CPMS never reimbursed the government, so if Potter's calculation is correct, the difference between what CPMS should have repaid the government and what it did repay the government is $5,219,195. There is no evidence that Appellants cooperated with the government, so the district court properly awarded treble damages under the statute in the amount of $15,657,585.

B. The District Court's Calculation of Damages Was Supported by the Evidence

Appellants argue that even if they are liable and the government has sustained damages, the district court's calculation of damages, based upon Potter's "what if" program, was incorrect because the intermediary never made any adjustments to the cost reports.

As discussed above, none of the disputed costs was allowable, so the intermediary would have disallowed all of the disputed costs in determining CPMS' repayment obligation. Potter's "what if" program simulated this process because he removed all disputed costs from the cost reports, which resulted in a figure of $5,219,195 representing overpayments made to CPMS. Even if CPMS believed that some of the costs should have been allowed, CPMS would still have had to repay Medicare $5,219,195 at the time it filed the cost reports, because challenges to an intermediary's determination of liability do not postpone a provider's obligation to repay the government the amount an intermediary initially determines to be due. *See* 42 C.F.R. § 405.1803(c). Thus, Potter's calculation and the district court's ultimate damages award was supported by the admissible evidence.

C. The Treble Damages Award Does Not Violate the Constitution

Finally, Appellants argue that even if they are liable, the government sustained damages and the

district court's calculation of damages was correct, an award of treble damages in this case is unconstitutional.

An award of treble damages and civil penalties under the FCA is, at least in part, punitive and subject to the Eighth Amendment's Excessive Fines Clause. *United States v. Mackby,* 339 F.3d 1013, 1016 (9th Cir. 2003). An award of treble damages under the FCA violates the Excessive Fines Clause if it is grossly disproportional to the gravity of a defendant's offense. *Id.* There is no rigid set of factors in deciding whether an award is grossly disproportional to the gravity of a defendant's offense, but we consider the following factors relevant: (1) the severity of the offense and its relation to other criminal activity; (2) the maximum penalty faced; (3) the harm caused and (4) whether the defendant falls within the class of persons targeted by the applicable law. *Id.* at 1016-17.

In this case, the second factor favors Appellants because the district court imposed treble damages and the maximum amount of allowable civil penalties. Yet we have found no law requiring a district court to award less than treble damages and the maximum amount of allowable civil penalties in an FCA case in order to satisfy the Excessive Fines Clause. The FCA, itself, instructs the district court to treble damages and provides the district court with limited discretion in calculating civil penalties. *See* 31 U.S.C. § 3729(a).

"Congress provided for treble damages and an automatic civil monetary penalty per false claim," which "shows that Congress believed that making a false claim to the government is a serious offense." *Mackby,* 339 F.3d at 1017. The government sustained harm to its treasury and to the integrity of the Medicare program itself. *Medshares Mgmt. Group, Inc.,* 400 F.3d at 456. And Appellants fall squarely among the class of people targeted by the FCA. *See Mackby,* 339 F.3d at 1017. Considering these factors, we cannot conclude that the district court's judgment is grossly disproportional to the gravity of Appellants' offenses.

V

Appellants are liable under the reverse false claims provision of the FCA for the submission of false statements in their 1997, 1998 and 1999 cost reports. The government sustained actual damages and is entitled to a treble damages award of $15,657,585 and a civil penalties award of $31,000.

AFFIRMED.

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, v. ROBERT I. BOURSEAU, et al., Defendants.	No. 03-cv-907-BEN (WMC) **FINDINGS OF FACT AND CONCLUSIONS OF LAW** (Filed Sep. 29, 2006)

To paraphrase Justice Oliver Wendell Holmes, Jr., "hospital operators must turn square corners when dealing with the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services."[1] This is an action brought by the United States Government against two psychiatric hospital operators for cutting corners or claiming to have turned square corners that did not actually exist.[2] The hospital operators are Mr. Robert I.

[1] "Men must turn square corners when dealing with the government." *Rock Island, Ark. & La. R.R. v. United States*, 254 U.S. 141, 143 (1920) (Holmes, J.).

[2] The Defendants defense to the Government's claim is essentially that the Medicare reimbursement statutes and regulations are sufficiently vague that their claims for payment cannot be deemed false claims. In other words, to again paraphrase, before a hospital operator can be penalized for not turning square corners, "it is crucial that they know where those corners are." Waxman, Seth P. and Fried, Charles, Motion for Leave to File Brief as *Amici Curiae*, *Northwest Airlines. Inc. v.*

(Continued on following page)

Bourseau and Dr. Rudra Sabaratnam, and their two single-employee corporations, RIB Medical Management Services, Inc. and Navatkuda, Inc.

The Government seeks damages flowing from the presentment of false claims under the federal False Claims Act ("FCA"), 31 U.S.C. §§3729-3733, and under California state causes of action for unjust enrichment and common law fraud. The asserted false claims were presented as Medicare reimbursable costs. The costs were itemized in three annual "cost reports" submitted by California Psychiatric Management Services ("CPMS"), which was doing business as Bayview Hospital & Mental Health Systems ("CPMS/Bayview Hospital" or "Bayview"). The costs were claimed as incurred for the treatment of Medicare patients at a psychiatric hospital in Chula Vista, California. The cost reports were submitted for the hospital's operations during the years 1997, 1998, and 1999. CPMS went into Bankruptcy twice: once in 1996 (emerging in 1998) and again in 2000. The Government has also filed creditor claims directly against CPMS in the 2000 CPMS bankruptcy case (which is still pending at this time).

Spirit Airlines, Inc., U.S. Supreme Court Case No. 06M7, On Petition for Writ of Certiorari (Filed Aug. 17, 2006).

A six day bench trial was held in July 2006 and having considered the evidence, the Court makes the following factual and legal findings.[3]

I. FINDINGS OF FACT

A. Entities

1. Plaintiff is the United States and brings this suit on behalf of the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, which administers the Medicare Program.

2. Bayview Hospital & Mental Health Systems, a psychiatric hospital in Chula Vista, California, was owned and operated by California Psychiatric Management Services (CPMS).

3. CPMS was a California Limited Partnership with two general partners: RIB Medical Management Services, Inc. and Navatkuda, Inc.

4. Robert I. Bourseau (Bourseau) served as President and the only employee of RIB Medical Management Services, Inc. Bourseau controlled RIB.

5. Dr. Rudra Sabaratnam (Sabaratnam), a licensed physician, served as President and the only full-time employee of Navatkuda, Inc. Dr. Sabaratnam controlled Navatkuda.

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[3] Some of the factual findings are contained in the Pre-Trial Order (signed May 5, 2006) and were stipulated to by both parties prior to the trial.

6. Bourseau focused an operations management while Dr. Sabaratnam focused on medical management.

7. Together, Bourseau and Dr. Sabaratnam, through RIB and Navatkuda, ran CPMS doing business as Bayview Hospital.

8. Bourseau signed CPMS/Bayview Hospital's 1997, 1998, and 1999 cost reports certifying that the reports were true, correct, and complete statements prepared from CPMS/Bayview Hospital's books and records in accordance with applicable instructions and that he was familiar with the laws and regulations regarding the provision of health care services, and that the services identified in the cost reports were provided in accordance with those laws and regulations.

9. While Dr. Sabaratnam focused on medical care at Bayview Hospital, he was familiar with the process of preparing and submitting hospital cost reports to Medicare. Prior to the submission of CPMS's 1997, 1998, and 1999 cost reports, Dr. Sabaratnam signed a hospital cost report for a hospital in Los Angeles, California (Ingleside Hospital).

B. <u>The Medicare Program</u>

10. The United States administers the hospital insurance benefits program for the aged and disabled, commonly referred to as "Medicare Part A," 42 U.S.C. §§ 1395c – 1395i-5. The Medicare program was established by Title XVIII of

the Social Security Act of 1965 (codified as amended at 42 U.S.C. §§ 1395-1395ggg).

11. The agency of the United States responsible for the Medicare program is the United States Department of Health and Human Services (HHS). *See, e.g.,* 42 U.S.C. §§ 1395b-1, 1395b-2, 1395b-3, 1395b-4, 1395b-7, 1395r, 1395u. The agency within HHS administering the program is the Centers for Medicare & Medicaid Services which prior to July 1, 2001, was known as the Health Care Financing Administration. Notice, 66 Fed. Reg. 35437 (2001).

12. Medicare Part A provides basic protection against the costs of hospital, related post-hospital, home health services, and hospice care. 42 U.S.C. § 1395c. Benefits include services provided by psychiatric hospitals. 42 U.S.C. § 1395d(c).

13. When electing to participate in the Medicare program, the provider enters into a contract with HHS-CMS in which the provider agrees to conform to all applicable statutory and regulatory provisions relating to Medicare reimbursement, including the provisions of Section 1866 of the Social Security Act and Title 42 of the Code of Federal Regulations.

C. Before CPMS' 1996 Bankruptcy

14. Between November 1991 and 1995, CPMS entered into contracts to manage psychiatric units in five hospitals in the Los Angeles, California area: South Bay Hospital, Mission Hospital (San Fernando Hospital and Panorama Hospital), L.A.

Metro Hospital, and Bellflower Hospital (the five Los Angeles Hospitals).

15. Pursuant to the management contracts with the five Los Angeles hospitals, CPMS agreed to provide management services for these hospital psychiatric units.

16. Each Los Angeles hospital submitted its own cost report to Medicare that included expenses for its psychiatric unit.

17. Each of the psychiatric units was housed in the respective Los Angeles hospitals.

18. Beginning in June 1993, CPMS entered into a series of financing arrangements with National Century Financial Enterprises, Inc. and its subsidiaries and affiliates, including but not limited to National Premier Financial Services, Inc. and its affiliates (collectively NCFE), in connection with CPMS' management of the psychiatric units in the Los Angeles hospitals.

19. CPMS leased the hospital buildings and campus known as Bayview Hospital in August 1994.

20. In or around September 1994, HHS-CMS accepted CPMS/Bayview Hospital's request to participate as a psychiatric hospital in the Medicare program. CPMS/Bayview Hospital's Provider Agreement was signed in August and September 1994. In its agreement with HHS-CMS, CPMS/Bayview Hospital agreed to conform to the provisions of Section 1866 of the Social Security Act and Title 42 of the Code of Federal Regulations.

21. CPMS/Bayview Hospital's Provider Agreement was terminated effective November 29, 2000.

22. Sometime prior to 1995, CPMS became engaged in litigation with the five Los Angeles Hospitals, and by 1995 all of the management agreements were terminated by those hospitals.

23. CPMS filed Home Office Cost Statements for 1994, 1995, and 1996, and identified as separate chain components of CPMS the following entities – Bayview Hospital, LA Metro, San Fernando, South Bay, Bellflower, and Panorama.

D. CPMS' 1996 Bankruptcy

24. On April 9, 1996, CPMS, voluntarily filed a petition in the United States Bankruptcy Court for the Central District of California under Chapter 11 of the Bankruptcy Code (Reorganization) (the 1996 Bankruptcy).

25. At the time of the 1996 Bankruptcy, National Century Financial Enterprises, Inc. and its subsidiaries and affiliates, including National Premier Financial Services, Inc. and its affiliates (collectively NCFE), claimed that CPMS was indebted to it in excess of $12 million.

26. In or around March 1998, the bankruptcy court approved a reorganization plan for CPMS which, among other things, gave NCFE a 49.9% limited partnership interest in CPMS.

27. As a result of NCFE acquiring a 49.9% limited partnership interest in CPMS in March 1998,

CPMS and NCFE became "related parties" as that term is used in the Medicare regulations.

E. Pacific Hospital Management and Mutual of Omaha

28. Before 1997, CPMS retained Pacific Hospital Management (PHM), Oakland, California, to prepare and transmit to Medicare, on CPMS's behalf, CPMS's cost reports. The PHM consultants handling the CPMS account were Paul Fayollat and Loretta Masi.

29. Fayollat had provided cost report preparation services to Bourseau or Dr. Sabaratnam since 1986.

30. The 1997, 1998, and 1999 Medicare cost reports for CPMS (Bayview Hospital) were preliminarily prepared by consultant Fayollat. Fayollat ultimately transmitted the cost reports to the Medicare fiscal intermediary.

31. Mutual of Omaha insurance Company (Mutual of Omaha) was the fiscal intermediary (FI) responsible for paying or reimbursing CPMS for CPMS/Bayview Hospital Medicare services and reviewing cost report accuracy and Medicare program compliance.

32. Cost reports are like income tax returns in that they are submitted by Medicare providers in the year following the year in which expenses were incurred and aggregate the Medicare costs incurred for the entire reporting year. CPMS submitted its 1997 cost report (for all costs incurred

during the 1997 calendar year) in the spring of 1998.

33. Neither Bourseau nor Dr. Sabaratnam submitted false or reckless claims on the assumption that the fiscal intermediary would catch and correctly calculate the values in the review process.

F. CPMS/Bayview Hospital's 1997 Cost Report – Claimed Interest and Bankruptcy Professional Fees

34. For CPMS/Bayview Hospital, Fayollat's firm prepared a preliminary 1997 cost report in May 1998. The preliminary 1997 cost report showed that CPMS would owe Medicare more than $1 million in Medicare overpayments made during 1997.

35. A meeting then took place around May 18, 1998, attended by Bourseau and Dr. Sabaratnam, Seth Morriss (CPMS' Director of Finance), and the consultants Fayollat and Masi.

36. One purpose of the May 18, 1998 meeting was to discuss ways to reduce the overall amount owed to Medicare.

37. One topic discussed at the meeting was whether some or all of the interest owed to NCFE, flowing from loans made to CPMS in earlier years, should be included on its 1997 cost report.

38. Another topic discussed at the meeting was whether some or all of the bankruptcy fees incurred by CPMS, should be included on its 1997 cost report.

39. Fayollat's professional judgment was that Medicare would disallow interest and bankruptcy legal fees unrelated to CPMS's operation of Bayview Hospital, since Bayview Hospital was the only avenue through which CPMS provided services to Medicare patients during the year 1997.

40. Fayollat advised Bourseau and Dr. Sabaratnam that the amounts that could be properly included in the CPMS/Bayview Hospital cost report would be limited to the amounts related to patient services at Bayview Hospital.

41. Fayollat also advised Bourseau and Dr. Sabaratnam in May 1998 that Medicare would not pay for expenses unrelated to Bayview Hospital that were included in the CPMS/Bayview Hospital cost report, and consequently that it was improper to include the full amount of the interest and bankruptcy legal fees in the 1997 CPMS/Bayview Hospital cost report.

42. Fayollat advised defendants that: (1) if it were up to him, he would not include interest and bankruptcy fees unrelated to Bayview Hospital in CPMS/Bayview Hospital's cost reports; and (2) Medicare would not pay for such expenses.

43. Notwithstanding Fayollat's advice, Bourseau directed Fayollat to include the total amount of the interest from 1997 ostensibly charged CPMS by NCFE ($2,550,722) and all of CPMS' bankruptcy legal fees incurred in 1997 ($1,303,383) on the CPMS/Bayview Hospital 1997 submitted cost report.

44. Bourseau made the decision to include the NCFE interest and bankruptcy legal fees with specific knowledge that none of the claimed interest expense incurred had been actually paid by CPMS, and that much of the claimed interest and much of the bankruptcy fees incurred originated from and were related to operations other than Bayview Hospital. These claims were submitted to the Government with knowledge or with reckless disregard as to their falsity.

45. With reckless disregard, Dr. Sabaratnam agreed with Bourseau's directive to Mr. Fayollat to include the full amount of the interest ostensibly charged CPMS by NCFE ($2,550,722) and all of CPMS's bankruptcy legal fees ($1,303,383) on the CPMS/Bayview Hospital 1997 submitted cost report.

46. The CPMS/Bayview Hospital 1997 cost report finally submitted to the Medicare fiscal intermediary included the full amount of interest ostensibly charged to CPMS by NCFE, and all of CPMS' bankruptcy legal fees.

47. The 1997 Medicare cost report filed by CPMS/Bayview Hospital included $2,550,722 in interest charged to CPMS by NCFE.

48. The 1997 Medicare cost report filed by CPMS/Bayview Hospital included $1,303,383 in bankruptcy professional fees.

49. No more than $405,000 of the $2,550,772 in interest claimed in CPMS/Bayview Hospital's 1997 cost report may have possibly related to debt incurred for the operation of Bayview Hospital. The

balance related to debt incurred by CPMS (prior to its first bankruptcy in 1996) while managing the psychiatric units in the five Los Angeles Hospitals which CPMS managed between 1993 and 1995.

50. No more than $443,239 of the $1,303,383 in bankruptcy legal fees claimed in CPMS/Bayview Hospital's 1997 cost report actually related to the operation of Bayview Hospital. The balance related to debts and disputes arising between CPMS and other creditors or debtors while managing the psychiatric units in the five Los Angeles Hospitals which CPMS managed between 1993 and 1995.

51. Neither in 1997, nor in 1998, did CPMS actually pay to NCFE any of the $2,550,772 interest claimed on CPMS/Bayview Hospital's 1997 cost report – whether it related to patient care at Bayview Hospital or to CPMS' pre-Bayview management services for the Los Angeles hospitals.

52. The 1997 interest was not identified in Bayview Hospital's internal accounting records in 1997.

G. CPMS/Bayview Hospital's 1998 Cost Report

53. For CPMS/Bayview Hospital, Fayollat's firm prepared a preliminary 1998 cost report in May 1999. The preliminary 1998 cost report showed that CPMS would owe Medicare a substantial amount from Medicare overpayments made during 1998.

54. A meeting took place around May 18, 1999, attended by Bourseau and Dr. Sabaratnam, Seth Morriss (CPMS' Director of Finance), and the consultants Fayollat and Masi.

55. One purpose of the May 18, 1999 meeting was to discuss ways to reduce the overall amount that would be owed to Medicare upon submission of the 1998 cost report.

i. Claimed Interest

56. Bourseau and Dr. Sabaratnam wanted all interest (approximately $2.7 million) ostensibly charged CPMS by NCFE claimed on CPMS/Bayview Hospital's 1998 cost report.

57. Fayollat advised Bourseau and Dr. Sabaratnam that in his view interest expenses for money borrowed for purposes unrelated to CPMS/Bayview Hospital were not reimbursable from Medicare.

58. Bourseau and Dr. Sabaratnam did not follow Fayollat's advice.

59. With reckless disregard, Bourseau made the decision to direct Fayollat to include all of the interest expense ostensibly owed to NCFE on CPMS/Bayview Hospital's 1998 cost report.

60. With reckless disregard, Dr. Sabaratnam agreed with Bourseau's directive to Fayollat to include the full amount of claimed NCFE interest on CPMS/Bayview Hospital's 1998 cost report.

61. The 1998 Medicare cost report filed by CPMS/Bayview Hospital included $2,761,803 in interest

ostensibly owed by CPMS to NCFE. None of the interest was actually paid to NCFE by CPMS during the year 1998, or the year 1999.

62. Only $547,756 of the $2,761,803 in interest claimed to have been incurred related to debt incurred for operating Bayview Hospital; $2,214,047 of the ostensible interest accrued related to debt incurred for the Psychiatric Units in the five Los Angeles Hospitals CPMS managed between 1993 and 1995.

63. Bourseau asserts that the 1997 accrued interest and part of the 1998 accrued interest was, in fact, paid by CPMS in 1999. However, his testimony and the single supporting contemporaneous document (an e-mail note) is unconvincing. Instead, what was described appears to have been a $4,000,000 paper loan without substance from NCFE to Defendants, to various of Defendant's entities, and back to NCFE as a much smaller credit against CPMS' debt to NCFE – which NCFE later characterized not as a credit towards CPMS's past debt but as a partial repayment by CPMS to NCFE of the new 1999 NCFE loan – and the balance of which was never actually paid by CPMS or credited on behalf of CPMS prior to CPMS's second bankruptcy (in 2000).

ii. Bankruptcy Professional Fees

64. As with the bankruptcy legal fees in CPMS/Bayview Hospital's 1997 cost report, Fayollat advised Bourseau and Dr. Sabaratnam that only those fees related to the operation of Bayview Hospital should be included in CPMS/Bayview Hospital's

1998 cost report. Bourseau and Dr. Sabaratnam did not follow Fayollat's advice. With reckless disregard, Bourseau and Dr. Sabaratnam decided to place in CPMS/Bayview Hospital's 1998 cost report all of the bankruptcy legal fees ($180,000) CPMS paid including fees unrelated to the operation of Bayview Hospital.

65. The Defendants' reckless disregard is best illustrated by Bourseau's own testimony at trial. In response to questioning about the propriety of including all of the bankruptcy fee costs as Medicare expenses claimed on CPMS' cost report, Bourseau testified that Fayolatt [sic] "*told me it was aggressive, but I still insisted because that was the only way we could get it paid.*"

iii. Claimed Lease Expense

66. During the May 12, 1999 meeting, Bourseau directed Fayollat to add to CPMS/Bayview Hospital's 1998 cost report a rent expense of $396,209 for a lease ostensibly with another entity controlled by Bourseau and Dr. Sabaratnam known as Intercare Resources.

67. With knowledge of its falsity, Bourseau and Dr. Sabaratnam directed that the fictitious rent expense be included in CPMS/Bayview Hospital's 1998 cost report.

68. There never was such a lease. The rent expense was fictitious.

iv. Square Footage

69. Also during the May 12, 1999 meeting, with reckless disregard, Bourseau directed and Dr. Sabaratnam agreed to have Fayollat increase the square footage reported in CPMS/Bayview Hospital's 1998 cost report by approximately 16,900 square feet, ostensibly for a partial hospitalization program.

70. CPMS/Bayview Hospital's 1998 cost report did include 16,965 additional square feet for a partial hospitalization program.

71. Very little of the additional square footage included in CPMS/Bayview Hospital's 1998 cost report was actually used for Medicare patient care or operational support during the year 1998.

v. Management Fees

72. CPMS/Bayview Hospital's 1998 cost report included $600,000 in management fees.

73. The management fees included in CPMS/Bayview Hospital's 1998 cost report reflected payment of $20,000 per month each to RIB, Navatkuda, and an NCFE entity.

74. Bourseau and Dr. Sabaratnam did actually perform management services for CPMS's Bayview Hospital operations during 1998. There was no evidence that the amount of management fees paid to Bourseau and Dr. Sabaratnam were substantially out of line with what other psychiatric hospital managers in Southern California were being paid.

75. No Bayview Hospital management was actually performed by NCFE.

76. Bourseau and Dr. Sabaratnam, with knowledge of its falsity, directed that $200,000 be included as NCFE management fees on the CPMS/ Bayview Hospital's 1998 cost report.

H. CPMS/Bayview Hospital's 1999 Cost Report

i. Bankruptcy Legal Fees

77. As with the bankruptcy legal fees in CPMS/ Bayview Hospital's 1997 cost report, Fayollat advised Bourseau and Dr. Sabaratnam that only those fees related to Bayview Hospital should be included in CPMS/Bayview Hospital's 1999 cost report. Bourseau and Dr. Sabaratnam did not follow Fayollat's advice. With reckless disregard, Bourseau and Dr. Sabaratnam decided to include in CPMS/Bayview Hospital's 1999 cost report all of CPMS' bankruptcy legal fees ($94,666).

ii. Inflated Space

78. With reckless disregard, Bourseau directed and Dr. Sabaratnam agreed to have Fayollat continue to include the increased square footage reported in CPMS/Bayview Hospital's 1999 cost report of approximately 16,900 square feet, ostensibly for a partial hospitalization program.

79. Very little of the additional square footage was used for patient care during the year 1999.

iii. Management Fees

80. CPMS/Bayview Hospital's 1999 cost report included $630,000 in management fees.

81. The management fees included in CPMS/ Bayview Hospital's 1999 cost report reflected payment of $20,000 per month each to RIB, Navatkuda, and an NCFE entity.

82. Bourseau and Dr. Sabaratnam did actually perform management services for CPMS's Bahyview Hospital operations during 1999. There was no evidence that the amount of management fees paid to Bourseau and Dr. Sabaratnam were substantially out of line with what other psychiatric hospital managers in Southern California were being paid.

83. No Bayview Hospital management was actually performed by NCFE.

84. Bourseau and Dr. Sabaratnam, with knowledge of its falsity, directed that $240,000 be included as NCFE management fees on the CPMS/ Bayview Hospital's 1999 cost report.

iv. Program Costs/Claimed Interest

85. CPMS/Bayview Hospital's 1999 cost report included a $336,859 expense listed as "program costs." This claim was for additional interest accrued and ostensibly payable to an NCFE entity.

86. NCFE was related to CPMS/Bayview Hospital since it was a 49.9% owner of CPMS.

87. The claimed interest was not actually paid by CPMS to NCFE in 1999 or 2000.

88. With reckless disregard, Bourseau made the decision to sign and submit the cost report including the interest expense accrued, but not paid, and ostensibly owed to NCFE, as "program costs" on CPMS/Bayview Hospital's 1999 cost report.

89. With reckless disregard, Dr. Sabaratnam agreed with Bourseau's decision to sign and submit the CPMS/Bayview Hospital 1999 cost report including the interest expense accrued, but not paid, and ostensibly owed to NCFE, as "program costs."

I. CPMS' Second Bankruptcy

90. On June 9, 2000, CPMS filed for bankruptcy for the second time.

91. To date, the government has recovered nothing on its claim in CPMS' second bankruptcy, which is still pending.

J. Overpayments Not Refunded

92. CPMS has not refunded to Medicare overpayments it received from Medicare during 1997 through 1999.

K. Damages and Penalties

93. Damages are as follows:

Year	False Claim Submitted	Damage
1997	Interest Claimed But Never Paid	$2,550,722
	Unrelated Bankruptcy Legal Fees	$860,144
1998	Interest Claimed But Never Paid	$2,761,803
	Unrelated Bankruptcy Legal Fees	$112,303
	Management Fees to NCFE	$180,000
	Non-Existent Lease Expense	$414,618
	Inflated Square Footage Effect on Reimbursement	$279,899
1999	Unrelated Bankruptcy Legal Fees	$ 53,535
	Management Fees to NCFE	$240,000
	Inflated Square Footage Effect on Reimbursement	$135,521
	Program Costs (Interest Claimed But Never Paid)	$336,899
Total		$7,925,444

M. Findings on Defendants' Affirmative Defenses

94. CPMS/Bayview Hospital's 1997 cost report was submitted no earlier than June 5, 1998.

95. There has been no conscious decision by any authorized agent of the United States permanently to abandon a right of recovery against defendants.

96. The United States seeks to recover money wrongfully paid from Medicare program dollars – a program funded by the American public for the benefit of the American public.

97. No facts exist to support defendants' estoppel affirmative defense.

98. Defendants did not act in good faith in submitting CPMS/Bayview Hospital's 1997, 1998, and 1999 cost reports.

99. Defendants did not fully disclose material facts that were known to them in their transmittal letters that accompanied CPMS/Bayview Hospital's 1997, 1998, and 1999 cost reports. Instead, any disclosures were calculated to mislead the fiscal intermediary and gloss over false or recklessly made claims contained in the cost reports.

100. Defendants could have, but did not, incorporate any of the nonallowable items in the cost reports for the purposes of establishing issues for appeal by following the Medicare Provider Reimbursement Manual procedure for "Cost Reports Filed Under Protest."

II. CONCLUSIONS OF LAW

A. Jurisdiction and Venue

This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1345, 31 U.S.C. § 3732(a), and its general equity jurisdiction. This Court has personal jurisdiction over the defendants because they submitted claims for payment to the United States from this district and received

payments from the United States in this district. Venue is proper in this district under 28 U.S.C. § 1391 and 31 U.S.C. § 3732(a) because defendants conducted business in this district, and a substantial part of the events giving rise to the causes of action in this case occurred in this district.

B. The Medicare Program

During the relevant time period, Medicare reimbursed psychiatric hospitals based on the actual costs incurred for the treatment of Medicare patients. To qualify for reimbursement, the cost must be: (1) for a Medicare-covered service, (2) related to patient care at the hospital, and (3) reasonable. 42 U.S.C. § 1395f(b); 42 C.F.R. § 413.9. A "reasonable cost" is the cost actually incurred by the provider for the service and excludes any part of the cost that is unnecessary in the efficient delivery of needed health services. 42 U.S.C. § 1395x(v)(1)(A).

The Medicare statute and regulations define a provider of service as a specific type of health care facility including "a hospital." 42 U.S.C. § 1395x(u); 42 C.F.R. § 400.202. Each hospital participates in the Medicare program by entering into an individual provider agreement with the Secretary of the Department of Health and Human Services (HHS). 42 U.S.C. § 1395cc. The statute further states that the "Secretary (of HHS) shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services

furnished by it. . . . " 42 U.S.C. § 1395g(a) (emphasis added). The regulations provide that "payment is to be made on the basis of current costs of the individual provider. . . . " 42 C.F.R. § 413.5(a) (emphasis added). In addition, the regulations provide that "reimbursement under the Medicare program involves a determination of – (1) Each provider's allowable costs for producing services. . . . " 42 C.F.R. § 413.50(a)(1) (emphasis added). Medicare pays only for the costs of caring for Medicare beneficiaries: "the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs. . . . " *Id.* One of the reasons that Medicare reimburses a hospital only for its own costs is to implement this statutory proscription. *See* 42 C.F.R. § 413.50(b).

To determine reimbursement amounts, Medicare apportions the provider's allowable indirect costs between Medicare patients and non-Medicare patients and then pays the share of the costs that relate to the Medicare patients. 42 C.F.R. § 413.50. As authorized by 42 U.S.C. § 1395h, HHS-CMS contracts with private insurance companies, referred to as "fiscal intermediaries," to pay providers of Part A services. The fiscal intermediaries pay providers using monies allocated by the United States from the Federal Hospital Insurance Trust Fund. *See* 42 U.S.C. § 1395i & 1395g.

Once a provider is authorized by Medicare to render Part A services, the fiscal intermediary will pay the provider an interim amount periodically throughout the year that is based on estimated treatment costs for the provider's Medicare patients. *See* 42 U.S.C. § 1395g(e). At the end of the year, the provider submits a final accounting of its costs for the year to the fiscal intermediary in a document called a "cost report." 42 C.F.R. § 413.20(b). The regulations further provide that fiscal intermediaries "will establish a basis for interim payments to each provider" based upon estimates. 42 C.F.R. § 413.60(a) (emphasis added). Further, "[a]t the end of the period, the actual apportionment, based upon the cost finding and apportionment methods selected by the provider, determines the Medicare reimbursement for the actual services provided to beneficiaries during the period." 42 C.F.R. § 413.60(b) (emphasis added).[4] The fiscal intermediary uses the cost report to determine

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[4] "Medicare provides that providers of services will be paid amounts that are determined to be due to them, but not sooner than on a monthly basis, with necessary adjustments caused by previously made overpayments or underpayments. Interim payments are made on the basis of estimated costs submitted by the hospital to Medicare. Actual costs reimbursable to a provider cannot be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment will be made at the end of the reporting period to bring the interim payments made to the provider during the period into agreement with the reimbursable amount payable to the provider for the services furnished to program beneficiaries during that period." 42 C.F.R. § 413.64(f).

the total reimbursement actually due the provider for Medicare services that year. Federal regulations require Part A providers to furnish the fiscal intermediary with accurate and sufficient data to ensure proper payment. 42 C.F.R. § 413.20(a); 413.20(d); 413.24(a).

The cost report is signed by the provider's administrator or chief financial officer. The signing official must also certify that the report is "true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted" 42 C.F.R. § 413.24(f)(4)(iv).

The signing official further certifies familiarity with the laws and regulations regarding the provision of health care services and attests that the services identified in the cost report were provided in compliance with those laws and regulations. *Id.*

Hospitals are required to remit a full refund of overpayments to Medicare at the time they file their cost reports. PRM § 2409.1(2). Other legal obligations of participating providers are:

a. not to make false statements or misrepresentations of material facts concerning payment requests, 42 U.S.C. §§ 1320a-7b(a)(1)&(2); 42 U.S.C. § 1320a-7a(1); 42 C.F.R. § 413.24(f)(4)(iv); 42 C.F.R. § 1001.101(a)(1); and

b. to know the information contained in HHS-CMS and fiscal intermediary notices, including manual issuances,

bulletins, and other written guides and directives, 42 C.F.R. § 411.406.

An organization related to a provider by common ownership or control is a "related party" to the provider. 42 C.F.R. §§ 413.17(a); 413.17(b). Costs applicable to services furnished to a provider by a related party are allowable only at the cost to the related party. 42 C.F.R. § 413.17(a). Management contracts with related parties must be specifically identified in the cost report so the fiscal intermediary can determine whether the management costs reflect the costs to the related party, whether the costs are within the price of comparable services that may be purchased elsewhere, and whether the provider acted as a prudent buyer. 42 C.F.R. § 413.17(a); *CMS Provider Reimbursement Manual 1* § 2135.3(A).

C. The False Claims Act

The FCA states that "[a]ny person" who "knowingly presents, or causes to be presented, to an officer or employee of the United States Government * * * a false or fraudulent claim for payment or approval," or who "knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government . . . " is liable to the government for civil penalties and treble damages. 31 U.S.C. 3729(a)(1), (a)(2). In 1986, Congress added section 3729(a)(7) – the so-called "reverse" false claim provision – which imposes liability on any person who "knowingly makes, uses,

or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government." The FCA imposes liability when: (1) a person presents, or causes the presentation of, a claim for payment or approval, or to decrease an obligation owed to, the Government; (2) the claim is false or fraudulent; and (3) the person acted knowingly. 31 U.S.C. § 3729(a)(1), (a)(2), (a)(7); *see, also, United States ex rel. A+ Homecare, Inc. v. Medshares Management Group, Inc.,* 400 F.3d 428, 450-51 (6th Cir. 2005).

i. Defendants Caused Presentment of the Claims

Regarding liability for causing the submission of a false claim, the FCA "was intended to reach all types of fraud, without qualification, that might result in a financial loss to the Government." *Neifert-White Co.,* 390 US. at 232 (1968). The FCA "reaches beyond 'claims' which might be legally enforced to all fraudulent attempts to cause the Government to pay out sums of money." *Id.* at 233. "The FCA 'reaches any person who knowingly *assisted* in causing the government to pay claims which were grounded in fraud without regard to whether that person had direct contractual relations with the government." *United States v. Mackby,* 261 F.3d 821, 827 (9th Cir. 2001) (quoting *United States ex rel. Marcus v. Hess,* 317 U.S. 537, 544-45 (1943)) (emphasis in *Mackby*). "Thus, a person need not be the one who actually

submitted the claim forms in order to be liable." *Mackby,* 261 F.3d at 827 (citing *United States v. Krizek,* 111 F.3d 934, 942 (D.C. Cir. 1997)). "'[T]he [FCA] is violated not only by a person who makes a false statement or a false record, . . . but also by one who engages in a fraudulent course of conduct that causes the government' to lose money by honoring a false claim." *United States v Raymond & Whitecomb Co.,* 53 F. Supp. 2d 436, 445 (S.D.N.Y. 1999) (citation omitted).

Bourseau and Dr. Sabaratnam caused the presentment of the claims. Bourseau served as Chairman of CPMS/Bayview Hospital's Board of Directors, President of RIB (the managing partner of CPMS), directed the inclusion of the costs on CPMS/Bayview Hospital's cost reports, and signed the cost reports certifying that they were true, correct, and complete statements prepared from CPMS/Bayview Hospital's books and records in accordance with applicable instructions. Dr. Sabaratnam was the CEO of CPMS/Bayview Hospital, President of Navatkuda (a general partner of CPMS), and agreed with Bourseau's direction to include the costs in CPMS/Bayview Hospital's cost reports.

ii. The Claims Were False

a. Interest

The $2,550,722 interest claim on CPMS/Bayview Hospital's 1997 cost report was nonallowable and a false claim because none of it was paid in 1997 or

within one year, and in fact, the claimed accrued interest amount was never paid by CPMS, 42 C.F.R. § 413.100(c)(2)(i)(A); the amount claimed substantially inflated the amount of interest incurred which was related to Medicare patient care at CPMS/ Bayview Hospital, 42 U.S.C. § 1395f(b); 42 C.F.R. § 413.9(a); it was not supported by adequate documentation, 42 C.F.R. 413.20(a); 413.20(d); 413.24(a); and it was not contained in CPMS/Bayview Hospital's financial records in 1997. PRM § 202.

The $2,761,803 interest claim on CPMS/Bayview Hospital's 1998 cost report was nonallowable and a false claim because none of it was paid in 1998 or within one year, and in fact, the claimed accrued interest amount was never paid by CPMS, 42 C.F.R. § 413.100(c)(2)(i)(A); the amount claimed substantially inflated the amount of interest incurred which was related to Medicare patient care at CPMS/ Bayview Hospital, 42 U.S.C. § 1395f(b); 42 C.F.R. § 413.9(a); it was not supported by adequate documentation, 42 C.F.R. 413.20(a); 413.20(d); 413.24(a); it was not contained in CPMS/Bayview Hospital's financial records in 1998, PRM § 202; and it was owed to a related party beginning in April 1998. 42 C.F.R. § 153(b)(3)(ii).

The $336,899 program cost on CPMS/Bayview Hospital's 1999 cost report was nonallowable and a false claim because it was really for accrued interest which was not paid in 1999 or within one year, and in fact, was never paid by CPMS, 42 C.F.R. § 413.100(c)(2)(i)(A); and it was not supported by

adequate documentation, 42 C.F.R. 413.20(a); 413.20(d); 413.24(a).

b. Bankruptcy Fees

The bankruptcy fees claimed on CPMS/Bayview Hospital's 1997, 1998, and 1999 cost reports to the extent they related to CPMS disputes arising out of non-Bayview hospital operations were nonallowable and a false claim made with reckless disregard for the truth because they substantially inflated the amount of fees incurred which were directly related to patient care at CPMS/Bayview Hospital, 42 U.S.C. § 1395f(b); 42 C.F.R. § 413.9(a); PRM § 2183; the documentation does not show that they were paid within one year, 42 C.F.R. § 413.100(c)(2)(i)(A); and they were not supported by adequate documentation. 42 C.F.R. 413.20(a); 413.20(d); 413.24(a).

c. Management Fees

The management fees claims on CPMS/Bayview Hospital's 1998 and 1999 cost reports were nonallowable and a false claim to the extent that fees paid to NCFE were claimed because NCFE provided no management services at all to CPMS/Bayview Hospital. 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 413.9(a). Additionally, the fees paid to NCFE were paid to a related party but not reduced to cost, 42 C.F.R. § 413.17(a); they were not supported by adequate documentation, 42 C.F.R. 413.20(a); 413.20(d); 413.24(a); PRM § 2135.2B; 2135.5; they exceeded the

price of comparable services that could be purchased elsewhere, 42 C.F.R. § 413.17(a); they exceeded what a prudent and cost conscious buyer would pay, PRM § 2103; they were not related to patient care at CPMS/Bayview Hospital, 42 U.S.C. § 1395f(b); 42 C.F.R. § 413.9(a); and the services ostensibly supplied duplicated services provided in-house. PRM § 2135.4(B).

d. Fictitious Rent

The rent expense of $396,209 on CPMS/Bayview Hospital's 1998 cost report was nonallowable and a false claim because the claimed expense was fictitious, 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 413.9(a).

e. Space

The 16,965 square feet increase in square footage for a PHP program on CPMS/Bayview Hospital's 1998 and 1999 cost reports was nonallowable and a false claim made with reckless disregard for the truth because it substantially inflated the amount of actual space used for patient care, 42 C.F.R. § 413.9(a); and it was not supported by adequate documentation, 42 C.F.R. 413.20(a); 413.20(d); 413.24(a). As between the Government and Defendants, Defendants were in the best position to bring forth evidence that additional space was actually used for delivering services to medicare patients; Defendants failed to present convincing evidence that the additional space was

actually used or necessary as back-up space for the provision of care to Medicare patients.

iv. Defendants Acted Knowingly

The FCA requires that a defendant know the claim is false or fraudulent. "Knowledge" includes actual knowledge, or acting in deliberate ignorance or with reckless disregard for the truth or falsity of the information. 31 U.S.C. § 3729(b); *United States ex rel. Oliver v. Parsons,* 195 F.3d 457, 464 (9th Cir. 1999). No specific intent to defraud the United States is required, 31 U.S.C. § 3729(b), and reckless disregard has been construed to be an extreme version of ordinary negligence. The focus of the knowledge element under the FCA is the defendant's knowledge of the falsity of its claims. Moreover, a provider that fails to inform itself of the reimbursement requirements acts in reckless disregard of the truth of its claims.

Bourseau and Dr. Sabaratnam acted with knowledge of the falsity of the fictitious lease claim, knowledge of the falsity of the accrued interest claims as none of the claimed interest was ever paid by CPMS, and with reckless disregard for the truth or falsity of the other false claims, in causing the submission to Medicare of the false costs on CPMS/Bayview Hospital's 1997, 1998, and 1999 cost reports. The false costs claimed were not the product of errors based upon merely flawed reasoning and differences in interpretation of disputed legal questions. Neither Bourseau nor Dr. Sabaratnam studied or consulted

the Medicare reimbursement statutes, regulations, or PRM, nor did they seek the advice of attorneys in arriving at their decisions to include the nonallowable and false claims in the 1997, 1998, and 1999 cost reports.

v. Defendants Conspired to Defraud Medicare

Bourseau and Dr. Sabaratnam agreed with each other to cause the submission by CPMS of the false claims as costs contained in CPMS/Bayview Hospital's 1997, 1998, and 1999 cost reports.

vi. Defendants Are Jointly and Severally Liable

Where one or more persons have acted together to submit false claims to the government in violation of the FCA, each is joint and severally liable for the treble damages and statutory penalty. Bourseau, Dr. Sabaratnam, RIB Medical Management Services, Inc. and Navatkuda, Inc. are each jointly and severally liable for the full recovery in this case. *United States of America v. Century Health Services,* 136 F.Supp.2d 876, 895 (M.D. Tenn. 2000) (corporate officers are liable in their individual capacities under the False Claims Act if they knowingly or with reckless disregard make false claims for payment on behalf of the corporation).

vii. Damages and Penalties

The damages in this case are $7,925,444. The United States is entitled to recover three times its single damages. The United States is entitled to recover treble damages in the amount of $23,776,332. The United States is entitled to judgment against Bourseau, Dr. Sabaratnam, RIB Medical Management Services, Inc. and Navatkuda, Inc., jointly and severally, in the amount of $23,776,332 for treble damages and penalties under the FCA.

Additionally, civil penalties of $10,000 (for the 1997 cost report), $10,000 (for the 1998 cost report), and $11,000 (for the 1999 cost report), for a total of $31,000 in civil penalties are imposed against Bourseau, Dr. Sabaratnam; RIB Medical Management Services, Inc. and Navatkuda, Inc., jointly and severally, pursuant to 31 U.S.C. § 3729(a).

D. Unjust Enrichment

The United States may recover for unjust enrichment against a person who has received benefits, the retention of which by that person would be unjust. *See, e.g., United States v. Applied Pharmacy,* 182 F.3d 603 (8th Cir. 1999); *Matarese v. Moore-McCormack Lines, Inc.*, 158 F.2d 631 (2d Cir. 1946); *Blusal Meats, Inc. v. United States,* 638 F. Supp. 824 (S.D.N.Y. 1986), *aff'd,* 817 F.2d 1007 (2d Cir. 1987).

The Government did not prove by a preponderance of the evidence that Defendants Robert Bourseau

or Dr. Sabaratnam were unjustly enriched by the Medicare overpayments to CPMS/Bayview Hospital, although CPMS monies were transferred back and forth between CPMS and their other business ventures in Villa View Hospital (also a CPMS entity), Hellman LLC, Intercare Resources, Ingleside Hospital, the City of Angels Hospital, N.P.S.I., and 1711 Temple LLC. Consequently, the Defendants are entitled to judgment against the Government on its claim of unjust enrichment.

E. Common Law Fraud

The Government did not prove by a preponderance of the evidence that any of the Defendants made false representations with the necessary intent to defraud or that the Government relied on the false representations. Therefore, the Government may not recover against any of the Defendants upon its claim for common law fraud.

F. Defendants' Affirmative Defenses

This case is ripe for adjudication. The statute of limitations for both the FCA and unjust enrichment claims is six years. 31 U.S.C. § 3731(b)(1); 28 U.S.C. § 2415(a). CPMS/Bayview Hospital's 1997 cost report was submitted in June 1998. The complaint was filed in May 2003, less than six years later. Consequently, the United States FCA and unjust enrichment claims are not time barred. The United States' common law fraud claim is governed by a three-year statute of

limitations, 28 U.S.C. § 2415(b), which is tolled for all periods during which "facts material to the right of action are not known and reasonably could not be known by an official of the United States charged with the responsibility to act in the circumstances." 28 U.S.C. § 2416(c). Accordingly, defendants' affirmative defense of statute of limitations is rejected.

Waiver is the voluntary, intentional relinquishment of a known right. *See, e.g., Trane Co. V. Whitehurst-Lassen Const. Co.,* 881 F.2d 996, 1003 (11th Cir. 1989); *Apponi v. Sunshine Biscuits,* 809 F.2d 1210, 1217 (6th Cir. 1987). There has been no such conscious decision by any authorized agent of the United States permanently to abandon a right to recovery against defendants. *See Utah Power & Light Co. v. U.S.,* 243 U.S. 389, 408-409 (1917); *Federal Crop Insurance Corp. v. Merrill,* 332 U.S. 380, 384 (1947); *Heckler v. Community Health Serv. of Crawford County, Inc.,* 467 U.S. 51 (1984). Accordingly, defendants' affirmative defense of waiver against the United States is rejected.

The equitable defense of laches may not be asserted against the United States.

The United States is not estopped from recovering for its claims in this case

Defendants did not act in good faith in causing the submission of false claims on CPMS/Bayview Hospital's 1997-1999 cost reports, Defendants' affirmative defense of good faith is rejected.

III. CONCLUSION

The United States is entitled to judgment against Robert I. Bourseau, Dr. Rudra Sabaratnam, RIB Medical Management Services, Inc., and Navatkuda, Inc., jointly and severally, in the amount of $23,776,332 for treble damages and $31,000 in civil penalties under the False Claims Act, Defendants are entitled to a judgment of non-liability against the United States on its claims of unjust enrichment and common law fraud.

IT IS SO ORDERED.

DATED: September 29, 2006

/s/ [Illegible]
Hon. Roger T. Benitez
United States District Judge

United States District Court
SOUTHERN DISTRICT OF CALIFORNIA

USA

V. JUDGMENT IN A CIVIL CASE

Bourseau, et al

CASE NUMBER: 03cv907 BEN (WMc)

☐ **Jury Verdict.** This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

☒ **Decision by Court.** This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED

the United States is entitled to judgment against Robert I. Bourseau, Dr. Rudra Sabaratnam, RIB Medical Management Services, Inc., and Navatkuda, Inc., jointly and severally, in the amount of $23,776,332 for treble damages and $31,000 in civil penalties under the False Claims Act. Defendants are entitled to a judgment of non-liability against the United States on its claims of unjust enrichment and common law fraud.....

September 29, 2006	W. Samuel Hamrick, Jr.
Date	Clerk
	S/J. Hathaway
	(By) Deputy Clerk
	ENTERED ON
	September 29, 2006

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, vs. ROBERT I. BOURSEAU, et al., Defendants.	CASE NO. 03cv907 BEN (WMc) **ORDER GRANTING PLAINTIFF'S AND DEFENDANT'S RULE 59(e) MOTIONS TO ALTER OR AMEND THE JUDGMENT** (Filed Dec. 1, 2006)

Now before the Court are motions by both Plaintiff and Defendants to alter or amend the Judgment pursuant to Federal Rules of Civil Procedure Rule 59(e). The motions are timely filed and this Court has jurisdiction. The motions are granted as follows.

I. PLAINTIFF'S MOTION

The Government moves to amend the Judgment to correct and reduce the amount of damages, reducing the amount of the judgment from $23,776,332 to $15,657,585. Defendants do not oppose the reduction. Therefore, the Motion is Granted. The Damages are reduced as follows

Year	False Claim Submitted	Original Damages	**Amended Damages**
1997	Interest Claimed But Never Paid	$2,550,722	**$1,494,753**
	Unrelated Bankruptcy Legal Fees	$860,144	**$421,470**
1998	Interest Claimed But Never Paid	$2,761,803	**$1,807,880**
	Unrelated Bankruptcy Legal Fees	$112,303	**$112,303**
	Management Fees to NCFE	$180,000	**$189,847**
	Non-Existent Lease Expense	$414,618	**$414,618**
	Inflated Square Footage Effect on Reimbursement	$279,899	**$279,899**
1999	Unrelated Bankruptcy Legal Fees	$53,535	**$53,535**
	Management Fees to NCFE	$240,000	**$118,798**
	Inflated Square Footage Effect on Reimbursement	$135,521	**$135,521**
	Program Costs (Interest Claimed But Never Paid)	$336,899	**$190,571**
Total		$7,925,444	**$5,219,195**

The total single damages is reduced from $7,925,444 to $5,219,195. At the same time, the total trebled damages is reduced from $23,776,332 to $15,657,585. The $31,000 of civil penalties remains unchanged.

II. DEFENDANTS' MOTION

Defendants also move to alter or amend seeking amended findings and challenging the damages as an excessive fine under the Eighth Amendment and a violation of the Due Process Clause of the Fifth Amendment.

A. Amended Findings

The motion is granted insofar as the Judgment will be altered to make explicit what was implicit previously: the false claims of the 1997, 1998, and 1999 Medicare Cost Reports for California Psychiatric Management Services ("CPMS") doing business as Bayview Hospital & Mental Health Systems ("Bayview") actually damaged the Government and are actionable both as affirmative false claims under 31 U.S.C. § 3729(a)(1), § 3729(a)(2) or §3729(a)(3), and as reverse false claims under § 3729(a)(7) adopting the reasoning of *United States, ex rel. A+ Homecare, Inc. v. Medshares Management Group, Inc.*, 400 F.3d 428 (6th Cir. 2005), *cert. denied,* 126 S.Ct. 797 (2005).

B. Eighth Amendment

The motion is granted insofar as the Court now considers whether the fines and trebled damages imposed here violate either the Eighth Amendment or the Due Process Clause. The Court finds they do not.

The trebled damages awarded do not violate the Eighth Amendment. In *United States v. Mackby,* 261 F.3d 821, 831 (9th Cir. 2001) ("*Mackby I*"), which the Defendants rely on[1], the Ninth Circuit concluded that the False Claims Act treble damages provision had a punitive element and was, therefore, subject to an Excessive Fines analysis under the Eighth Amendment. Two years later, the Supreme Court determined that the treble damages provision of the False Claims Act also has "a compensatory side, serving remedial purposes in addition to punitive objectives." *Cook County, Illinois v. United States*, 538 U.S. 119, 130 (2003). In fact, *Cook County* suggests that in a False Claims Act case much of the trebled damages award serves a compensatory purpose. The Supreme Court observes that there is "no question that some liability beyond the amount of the fraud is usually necessary to compensate the Government completely for the costs, delays, and inconveniences occasioned by fraudulent claims." *Id.* Earlier, in *United States v.*

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[1] Defendants discuss *Mackby I*, but do not mention the Ninth Circuit opinion following remand known as "*Mackby II*" – which is odd since the excellent defense counsel in the present case was also Peter Mackby's counsel in the two *Mackby* appeals.

Halper, 490 U.S. 435, 445 (1989), the Supreme Court found that the injury from the presentment of a false claim is "not merely the amount of the fraud itself, but also ancillary costs, such as the costs of detection and investigation, that routinely attend the Government's efforts to root out deceptive practices directed at the public purse." Moreover, the *Cook County* decision notes that trebled damages help compensate the Government in the absence of a separate provision for consequential damages and prejudgment interest.[2] *Id.* at 131 and n.9 ("The treble damages provision was, in a way, adopted by Congress as a substitute for consequential damages.").

In the *Mackby* litigation following remand and coming after the *Cook County* decision, the Ninth Circuit held that treble damages and fines awarded under the False Claims Act in that case did not violate the Excessive Fines Clause where the size of the penalty was "not grossly disproportional to [defendant's] level of culpability and the harm he caused." *United States v. Mackby,* 339 F.3d 1013, 1017 (9th Cir. 2003), *cert. denied*, 124 S.Ct. 1657 (2004) ("*Mackby II*").

Here, a large portion of the trebled damages award of $15,657,585 is compensatory in nature. The remaining smaller portion which may be punitive and

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[2] Prejudgment interest could be significant in this case because the three fraudulent Cost Reports were delivered six, seven, and eight years ago.

the fines of $31,000 are not grossly disproportional to the Defendants' level of culpability and the harm that the Defendants caused. As in *Mackby II,* the false claims here harmed the Government "in the form of both monetary damages and harm to the administration and integrity of Medicare." *Id.* at 1018. In *Mackby II,* the Ninth Circuit explains that, "[t]he government has a strong interest in preventing fraud, and the harm of such false claims extends beyond the money paid out of the treasury." *Id.* at 1019, *Mackby II* continues, "[f]raudulent claims make the administration of Medicare more difficult, and widespread fraud would undermine public confidence in the system." *Id.* Finally, dollars fraudulently obtained from the public fist by unscrupulous or reckless medical services providers, exhaust the Medicare resources which are set aside for deserving Medicare patients.

For all of these reasons, this Court concludes that the amount of damages and penalties found in this case does not violate the Excessive Fines Clause.

C. Due Process Clause

Defendants also argue that the trebled damages are punitive damages that violate the Due Process Clause of the Fifth Amendment. In *State Farm Mutual Automobile Insurance Company v. Campbell*, 538 U.S. 408 (2003), which Defendants rely on, the

Supreme Court held that punitive damages awarded by a jury may implicate the Due Process Clause.[3] The damages award here, however, is not the product of a jury verdict and does not have the potentially arbitrary quality of a classic punitive damages award. *Cook County, Illinois*, 538 U.S. at 132 ("Treble damages certainly do not equate with classic punitive damages, which leave the jury with open-ended discretion over the amount . . . "). Defendants do not cite, and this Court has not found, a decision holding that a trebled damage award imposed under the False Claims Act violates the Due Process Clause. In view of the mixed compensatory and punitive nature of False Claims Act trebled damages, the Court finds that the damages imposed against the Defendants in this case do not offend the Due Process Clause.

III. CONCLUSION

Both motions are granted. The Findings of Fact and Conclusions of Law and Judgment are, hereby, amended. The Medicare Cost Reports are actionable as false claims under 31 U.S.C. § 3729(a)(1), §3729(a)(2) or §3729(a)(3), and as reverse false claims under

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[3] Commentators note that *State Farm* suggests punitive damages awards that exceed a multiple of nine times compensatory damages could be, but are not necessarily, arbitrary and may run afoul of the Due Process Clause. *Cf. Phillip* [sic] *Morris USA v. Williams*, U.S. Supreme Court Case No. 05-1256 (oral arguments on October 31, 2006 regarding constitutionality of large punitive damages award exceeding 9 to 1 ratio).

§ 3729(a)(7). The amount of actual damages is reduced to $5,219,195. The amount of trebled damages is reduced to $15,657,585. The fines and trebled damages imposed here do not violate either the Excessive Fines Clause of the Eighth Amendment or the Due Process Clause of the Fifth Amendment.

IT IS SO ORDERED.

DATED: December 1, 2006

/s/ Roger Benitez
Hon. Roger T. Benitez
United States District Judge

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA,
Plaintiff-Appellee,
v.
ROBERT I. BOURSEAU,
Defendant-Appellant,
RIB MEDICAL MANAGEMENT SERVICES, INC., a California corporation,
Defendant-Appellant,
and
RUDRA SABARATNAM,
Defendant,
NAVATKUDA, INC., a California corporation,
Defendant.

No. 06-56741
D.C. No. CV-03-00907-RTB
Southern District of California, San Diego

MANDATE

(Filed Aug. 27, 2008)

UNITED STATES OF AMERICA,
Plaintiff-Appellee,
v.
ROBERT I. BOURSEAU,
Defendant,

RIB MEDICAL MANAGEMENT SERVICES, INC., a California corporation, Defendant, and RUDRA SABARATNAM, Defendant-Appellant, NAVATKUDA, INC., a California corporation, Defendant-Appellant.	No. 06-56743 D.C. No. CV-03-00907-RTB Southern District of California, San Diego **MANDATE**

The judgment of this Court, entered 07/14/2008, takes effect this date. This constitutes the formal mandate of this Court issued pursuant to Rule 41(a) of the Federal Rules of Appellate Procedure.

FOR THE COURT:

Molly C. Dwyer
Clerk of Court

By: Theresa Benitez
Deputy Clerk

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA,

Plaintiff-Appellee,

v.

ROBERT I. BOURSEAU,

Defendant-Appellant,

RIB MEDICAL MANAGEMENT SERVICES, INC., a California corporation,

Defendant-Appellant,

and

RUDRA SABARATNAM,

Defendant,

NAVATKUDA, INC., a California corporation,

Defendant.

No. 06-56741

D.C. No. CV-03-00907-RTB
Southern District of California, San Diego

ORDER

(Filed Aug. 19, 2008)

UNITED STATES OF AMERICA,

Plaintiff-Appellee,

v.

ROBERT I. BOURSEAU,

Defendant,

RIB MEDICAL MANAGEMENT SERVICES, INC., a California corporation, Defendant, and RUDRA SABARATNAM, Defendant-Appellant, NAVATKUDA, INC., a California corporation, Defendant-Appellant.	No. 06-56743 D.C. No. CV-03-00907-RTB Southern District of California, San Diego

Before: BEEZER, HALL, and SILVERMAN, Circuit Judges.

The panel has voted to deny the petition for panel rehearing, Judge Silverman votes to deny the petition for rehearing en banc and Judges Beezer and Hall so recommend.

The full court has been advised of the petition for rehearing en banc and no judge has requested a vote to rehear the matter en banc. Fed. R. App. P. 35.

The petition for panel rehearing and the petition for rehearing en banc are DENIED.

Provider Reimbursement

As adopted, Trans. No. 5 (May 1968) and amended by Trans. No. 38 (June 1971).

[¶ 7338] Tentative Retroactive Adjustment (Prov. Reimb. Man., Part 1, § 2408.2)

To reimburse the provider as quickly as possible, a tentative adjustment is made as soon as the cost report is received and reviewed by the intermediary. This adjustment includes an incentive payment (see 42 CFR 413.40(d)(2)) in the case of a hospital whose allowable inpatient operating costs per discharge are less than its target rate amount.

For purposes of a tentative retroactive adjustment, costs are accepted as reported except for obvious errors or inconsistencies – subject to later audit. Such a tentative adjustment is not made, however, where one of the following conditions exists:

- The cost report has been filed by a terminated provider or the former owner of a provider which has changed ownership;

- The intermediary knows at the time the cost report is received and reviewed that the provider is insolvent under the laws of the State in which it is located or that a petition of bankruptcy or insolvency is pending against the provider in any State of Federal court; or

- A change of ownership has occurred and the intermediary is not satisfied with the acceptability under program regulations of any increase

in the recognized basis for depreciation of the facility as claimed by the new owner.

Where one of these conditions exists, any retroactive adjustments necessary on the cost report are made at the time the cost report is settled.

To avoid creating an overpayment when making a tentative adjustment, the intermediary reduces the payment by any amounts claimed which are attributable to obvious errors or inconsistencies in the cost report, as well as by any monies owed the program by the provider, e.g., a past due accelerated payment or an unrecovered overpayment.

In addition, further reductions in the tentative retroactive adjustment payment may be required where the intermediary has not made a final retroactive adjustment for a previous period of the provider's operations because a portion of the provider's costs to be borne by the program is not resolved. To the extent that the Medicare portion of the unresolved costs for the previous period was not deducted, from the tentative retroactive adjustment payment for the previous period, it is deducted from the current tentative adjustment payment. Where reimbursement for similar costs is claimed for the period for which the current tentative retroactive adjustment is being made, the Medicare portion of such unresolved costs is also deducted from the tentative adjustment payment.

Health Care Financing Administration, HHS

§ 413.64 Payments to providers: Specific rules.

(a) *Reimbursement on a reasonable cost basis.* Providers of services paid on the basis of the reasonable cost of services furnished to beneficiaries will receive interim payments approximating the actual costs of the provider. These payments will be made on the most expeditious schedule administratively feasible but not less often than monthly. A retroactive adjustment based on actual costs will be made at the end of a reporting period.

(b) *Amount and frequency of payment.* Medicare states that providers of services will be paid the reasonable cost of services furnished to beneficiaries. Since actual costs of services cannot be determined until the end of the accounting period, the providers must be paid on an estimated cost basis during the year. While Medicare provides that interim payments will be made no less often than monthly, intermediaries are expected to make payments on the most expeditious basis administratively feasible. Whatever estimated cost basis is used for determining interim payments during the year, the intent is that the interim payments shall approximate actual costs as nearly as is practicable so that the retroactive adjustment based on actual costs will be as small as possible.

(c) *Interim payments during initial reporting period.* At the beginning of the program or when a

provider first participates in the program, it will be necessary to establish interim rates of payment to providers of services. Once a provider has filed a cost report under the Medicare program, the cost report may be used as a basis for determining the interim rate of reimbursement for the following period. However, since initially there is no previous history of cost under the program, the interim rate of payment must be determined by other methods, including the following:

(1) If the intermediary is already paying the provider on a cost or cost-related basis, the intermediary will adjust its rate of payment to the program's principles of reimbursement. This rate may be either an amount per inpatient day, or a percent of the provider's charges for services furnished to the program's beneficiaries.

(2) If an organization other than the intermediary is paying the provider for services on a cost or cost-related basis, the intermediary may obtain from that organization or from the provider itself the rate of payment being used and other cost information as may be needed to adjust that rate of payment to give recognition to the program's principles of reimbursement.

(3) It [sic] no organization is paying the provider on a cost or cost-related basis, the intermediary will obtain the previous year's financial statement from the provider. By analysis of such statement in

light of the principles of reimbursement, the intermediary will compute an appropriate rate of payment.

(4) After the initial interim rate has been set, the provider may at any time request, and be allowed, an appropriate increase in the computed rate, upon presentation of satisfactory evidence to the intermediary that costs have increased. Likewise, the intermediary may adjust the interim rate of payment if it has evidence that actual costs may fall significantly below the computed rate.

(d) *Interim payments for new providers.* (1) Newly-established providers will not have cost experience on which to base a determination of an interim rate of payment. In such cases, the intermediary will use the following methods to determine an appropriate rate:

(i) If there is a provider or providers comparable in substantially all relevant factors to the provider for which the rate is needed, the intermediary will base an interim rate of payment on the costs of the comparable provider.

(ii) If there are no substantially comparable providers from whom data are available, the intermediary will determine an interim rate of payment based on the budgeted or projected costs of the provider.

(2) Under either method, the Intermediary will review the provider's cost experience after a period of three months. If need for an adjustment is indicated,

the interim rate of payment will be adjusted in line with the provider's cost experience.

(e) *Interim payments after initial reporting period.* Interim rates of payment for services provided after the initial reporting period will be established on the basis of the cost report filed for the previous year covering medicare services. The current rate will be determined – whether on a per diem or percentage of charges basis – using the previous year's costs of covered services and making any appropriate adjustments required to bring, as closely as possible, the current year's rate of interim payment into agreement with current year's costs. This interim rate of payment may be adjusted by the intermediary during an accounting period if the provider submits appropriate evidence that its actual costs are or will be significantly higher than the computed rate. Likewise, the intermediary may adjust the interim rate of payment if it has evidence that actual costs may fall significantly below the computed rate.

(f) *Retroactive adjustment.* (1) Medicare provides that providers of services will be paid amounts determined to be due, but not less often than monthly, with necessary adjustments due to previously made overpayments or underpayments. Interim payments are made on the basis of estimated costs. Actual costs reimbursable to a provider cannot be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment will be made at the end of the reporting period to bring the interim payments made to the provider during

the period into agreement with the reimbursable amount payable to the provider for the services furnished to program beneficiaries during that period.

(2) In order to reimburse the provider as quickly as possible, an initial retroactive adjustment will be made as soon as the cost report is received. For this purpose, the costs will be accepted as reported, unless there are obvious errors or inconsistencies, subject to later audit. When an audit is made and the final liability of the program is determined, a final adjustment will be made.

(3) To determine the retroactive adjustment, the amount of the provider's total allowable cost apportioned to the program for the reporting year is computed. This is the total amount of reimbursement the provider is due to receive from the program and the beneficiaries for covered services furnished during the reporting period. The total of the interim payments made by the program in the reporting year and the deductibles and coinsurance amounts receivable from beneficiaries is computed. The difference between the reimbursement due and the payments made is the amount of the retroactive adjustment.

(g) *Accelerated payments to providers.* Upon request, an accelerated payment may be made to a provider of services that is not receiving periodic interim payments under paragraph (h) of this section if the provider has experienced financial difficulties due to a delay by the intermediary in making

payments or in exceptional situations, in which the provider has experienced a temporary delay in preparing and submitting bills to the intermediary beyond its normal billing cycle. Any such payment must be approved first by the intermediary and then by HCFA. The amount of the payment is computed as a percentage of the net reimbursement for unbilled or unpaid covered services. Recovery of the accelerated payment may be made by recoupment as provider bills are processed or by direct payment.

(h) *Periodic interim payment method of reimbursement* – (1) *Covered services furnished before July 1, 1987.* In addition to the regular methods of interim payment on individual provider billings for covered services, the periodic interim payment (PIP) method is available for Part A hospital and SNF inpatient services and for both Part A and Part B HHA services.

(2) *Covered services furnished on or after July 1, 1987.* Effective with claims received on or after July 1, 1987, the periodic interim payment (PIP) method is available for the following:

(i) Part A inpatient hospital services furnished in hospitals that are excluded from the prospective payment systems under subpart B of part 412 of this chapter.

(ii) Part A services furnished in hospitals receiving payment in accordance with a demonstration project authorized under section 402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Public

Law 92-603 (42 U.S.C. 1395b-1 (note)), or a State reimbursement control system approved under section 1886(c) of the Act and subpart C of part 403 of this chapter, if that type of payment is specifically approved by HCFA as an integral part of the demonstration or control system. If that type of payment is not an integral part of the demonstration or control system, PIP is available for the hospital under paragraph (h)(1)(i) of this section for hospitals excluded from the prospective payment systems or under § 412.116(b) of this chapter for prospective payment hospitals.

(iii) Part A SNF services.

(iv) Part A and Part B HHA services.

(v) Part A services furnished in hospitals paid under the prospective payment system, including distinct part psychiatric or rehabilitation units, as described in § 412.116(b) of this chapter.

(vi) Services furnished in a hospice as specified in part 418 of this chapter. Payment on a PIP basis is described in § 418.307 of this chapter.

(3) Any participating provider furnishing the services described in paragraph (h)(1) of this section that establishes to the satisfaction of the intermediary that it meets the following requirements may elect to be reimbursed under the PIP method, beginning with the first month after its request that the intermediary finds administratively feasible:

(i) The provider's estimated total Medicare reimbursement for inpatient services is at least $25,000 a year computed under the PIP formula or, in the case of an HHA, either its estimated –

(A) Total Medicare reimbursement for Part A and Part B services is at least $25,000 a year computed under the PIP formula; or

(B) Medicare reimbursement computed under the PIP formula is at least 50 percent of estimated total allowable cost.

(ii) The provider has filed at least one completed Medicare cost report accepted by the intermediary as providing an accurate basis for computation of program payment (except in the case of a provider requesting reimbursement under the PIP method upon first entering the Medicare program).

(iii) The provider has the continuing capability of maintaining in its records the cost, charge, and statistical data needed to accurately complete a Medicare cost report on a timely basis.

(iv) The provider has repaid or agrees to repay any outstanding current financing payment in full, such payment to be made before the effective date of its requested conversion from a regular interim payment method to the PIP method.

(4) No conversion to the PIP method may be made with respect to any provider until after that provider has repaid in full its outstanding current financing payment.

(5) The intermediary's approval of a provider's request for reimbursement under the PIP method will be conditioned upon the intermediary's best judgment as to whether payment can be made to the provider under the PIP method without undue risk of its resulting in an overpayment because of greatly varying or substantially declining Medicare utilization, inadequate billing practices, or other circumstances. The intermediary may terminate PIP reimbursement to a provider at any time it determines that the provider no longer meets the qualifying requirements or that the provider's experience under the PIP method shows that proper payment cannot be made under this method.

(6) Payment will be made biweekly under the PIP method unless the provider requests a longer fixed interval (not to exceed one month) between payments. The payment amount will be computed by the intermediary to approximate, on the average, the cost of covered inpatient or home health services furnished by the provider during the period for which the payment is to be made, and each payment will be made two weeks after the end of such period of services. Upon request, the intermediary will, if feasible, compute the provider's payments to recognize significant seasonal variation in Medicare utilization of services on a quarterly basis starting with the beginning of the provider's reporting year.

(7) A provider's PIP amount may be appropriately adjusted at any time if the provider presents or the intermediary otherwise obtains evidence relating

to the provider's costs or Medicare utilization that warrants such adjustment. In addition, the intermediary will recompute the payment immediately upon completion of the desk review of a provider's cost report and also at regular intervals not less often than quarterly. The intermediary may make a retroactive lump sum interim payment to a provider, based upon an increase in its PIP amount, in order to bring past interim payments for the provider's current cost reporting period into line with the adjusted payment amount. The objective of intermediary monitoring of provider costs and utilization is to assure payments approximating, as closely as possible, the reimbursement to be determined at settlement for the cost reporting period. A significant factor in evaluating the amount of the payment in terms of the realization of the project Medicare utilization of services is the timely submittal to the intermediary of completed admission and billing forms. All providers must complete billings in detail under this method as under regular interim payment procedures.

(i) *Bankruptcy or insolvency of provider*: If on the basis of reliable evidence, the intermediary has a valid basis for believing that, with respect to a provider, proceedings have been or will shortly be instituted in a State or Federal court for purposes of determining whether such provider is insolvent or bankrupt under an appropriate State or Federal law, any payments to the provider will be adjusted by the intermediary, notwithstanding any other regulation or program instruction regarding the timing or

manner of such adjustments, to a level necessary to insure that no overpayment to the provider is made.

(j) *Interest payments resulting from judicial review* – (1) *Application.* If a provider of services seeks judicial review by a Federal court (see § 405.1877 of this chapter) of a decision furnished by the Provider Reimbursement Review Board or subsequent reversal, affirmation, or modification by the Secretary, the amount of any award of such Federal court will be increased by interest payable by the party against whom the judgment is made (see § 413.153 for treatment of interest). The interest is payable for the period beginning on the first day of the first month following the 180-day period which began on either the date the intermediary made a final determination or the date the intermediary would have made a final determination had it been done on a timely basis (see §§ 405.1835(b) and 405.1841(a) of this chapter).

(2) *Amount due.* Section 1878(f) of the Act, 42 U.S.C. 1395oo(f), authorizes a court to award interest in favor of the prevailing party on any amount due as a result of the court's decision. If the intermediary withheld any portion of the amount in controversy prior to the date the provider seeks judicial review by a Federal court, and the Medicare program is the prevailing party, interest is payable by the provider only on the amount not withheld. Similarly, if the Medicare program seeks to recover amounts previously paid to a provider, and the provider is the prevailing party, interest on the amounts previously

paid to a provider is not payable by the Medicare program since that amount had been paid and is not due the provider.

(3) *Rate.* The amount of interest to be paid is equal to the rate of return on equity capital (see § 413.157) in effect for the month in which the civil action is commenced.

Example: An intermediary made a final determination on the amount of Medicare program reimbursement on June 15, 1974, and the provider appealed that determination to the Provider Reimbursement Review Board. The Board heard the appeal and rendered a decision adverse to the provider. On October 28, 1974, the provider commenced civil action to have such decision reviewed. The rate of return on equity capital for the month of October 1974 was 11.625 percent. The period for which interest is computed begins on January 1, 1975, and the interest beginning January 1, 1975, would be at the rate of 11.625 percent per annum.

[51 FR 34793, Sept. 30, 1986, as amended at 51 FR 42238, Nov. 24, 1986; 53 FR 1628, Jan. 21, 1988; 57 FR 39830, Sept. 1, 1992; 59 FR 36713, July 19, 1994]

* * *

[LOGO]
Mutual of Omaha
Companies

Contractor for
MEDICARE

[Address Omitted In Printing]

July 16, 1997

Mr. Glenn M. Pelkey, Controller
Bayview Hospital and Mental Health
330 Moss Street
Chula Vista, CA 91911

Provider No. 05-4139
F.Y.E 12/31/97

Dear Mr. Pelkey:

We have completed a review of your Medicare reimbursement rates based on the as-submitted cost report for the period ending December 31, 1996.

As a result of this review, we will be decreasing your part A rate from $715 to $695. Your Part B rate will remain at 55%. Your new Part A rate will be effective with all claims processed on or after August 1, 1997.

If you have any questions, please contact me at (402) 351-5372.

Sincerely,

/s/ Susan K. Teutschmann
Susan K. Teutschmann
Senior Accountant/Analyst
Medicare Audit & Reimbursement

cc:
Ms. Loretta Masi, Consultant
Pacific Hospital Management
1433 Webster St. Suite 202
Oakland, CA 94612

[LOGO]
Mutual of Omaha
Companies

Contractor for
MEDICARE

[Address Omitted In Printing]

July 16, 1997

Mr. Glenn M. Pelkey
Controller
Bayview Hosp & Mental Hlth
330 Moss Street
Chula Vista, CA 91911

Provider No. 05-4139
FYE: December 31, 1996

Dear Mr. Pelkey:

A review of our correspondence files indicates a bankruptcy occurred on April 9, 1996.

According to HCFA Publication, Chapter 15-1, Section 2408.2.a, a tentative adjustment will not be made when a cost report has been filed by a provider with a pending petition of bankruptcy or insolvency. We therefore can not [sic] process a tentative settlement for this cost report.

A final settlement will be done within one year of the date of receipt of this cost report. We will make every attempt to complete a final settlement in a timely manner for this cost report.

If you have any additional questions or concerns, please call me at (402) 351-3919.

Sincerely,

/s/ Amy E. Crofoot	Loretta Masi
Amy Crofoot	Paul Fayollat
Reimbursement Analyst	For your Files
Medicare Audit & Reimbursement	
cc: Lori Craft	714 846 6326
cc: Sandy Hoffman	415 354 0504
	Pet 23JUL1997

2409.1 *Overpayments Due to Excessive Interim Rates or Failure to File Cost Reports.* – The problems arising from excessive interim rates and failure to file cost reports can be divided into two broad categories: (1) the provider is participating in the program, and (2) the provider is no longer participating.

A. Provider Participating in Program. –

* * *

2. *Cost Report is Filed.* – When the provider files a cost report indicating that an overpayment has occurred a full refund is to be remitted with the report. If the provider does not remit full refund with the cost report, or, in cases where the intermediary discovers an overpayment during desk review, field audit, or final settlement, the intermediary will immediately send the first demand letter requesting a lump-sum refund. Recovery will be undertaken even though the provider disputes in whole or in part the intermediary's determination of the overpayment.

If the provider cannot refund the total amount of the overpayment within 30 days after receiving the letter, it should immediately request an extended repayment schedule. The intermediary may establish a repayment schedule of up to 12 months to recover all or part of an overpayment. It must offset any money owed to the provider prior to establishing a repayment plan. When a repayment schedule is used to recover part of an overpayment, the remaining amount should be recovered by the reduction of

interim payments to the provider or by lump-sum payment by the provider.

The provider must document its need for extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. The intermediary will send the provider written notification of the approved repayment schedule, which will be in effect from the date the provider submits the proposal. If an audit later uncovers an additional overpayment, the provider must submit further documentation if it wishes to request an extended repayment schedule for the additional amount.

If a provider demonstrates that repayment within a 12-month period would create extraordinary financial hardship, it may ask the intermediary to approve a longer period of extended repayment.

After an extended repayment schedule has been approved, the intermediary will monitor the case to be certain that the provider is making payments on time. If for any reason, it appears that the provider's installment payments will not liquidate the overpayment on schedule (e.g., the provider does not adhere to the repayment schedule or a lessening of use by Medicare beneficiaries results in diminished interim payments), the intermediary will attempt to renegotiate the amount of the installment payments in order to recoup the overpayment within the time frame originally agreed upon.

If the provider does not respond affirmatively within 30 days after the date of the first demand letter, the intermediary will send a second demand letter notifying the provider of the adjustment of interim payments. (If payments have not been completely suspended, the letter will state that interim payments will be suspended in 30 days if repayment arrangements are not made.) If the Provider does not affirmatively respond, a third demand letter will be sent 30 days after the date of the second letter and will contain further notification of the suspension of all interim payments.

* * *

HCFA
Health Care
Financing Administration

[Address Omitted In Printing]

MEDICARE
Part A Intermediary
Phone 402-351-5381

November 17, 1990

Mr. Glen M Pelkey, Controller
Bayview Hospital & Mental Health
330 Moss Street
Chula Vista, CA 91911

RE Provider No. 05-4139
FYE December 31, 1998

Dear Mr. Pelkey:

Your As submitted cost report indicates your facility was overpaid in the amount of $338,221.00. Since your organization has filed for bankruptcy, we are prohibited from making demands regarding this debt. The overpayment case will be referred to the Health Care Financing Administration Office in San Francisco, for handling of collection activity.

As submitted Overpayment	**$338,221.00**
Balance Due Medicare Program	**$338,221.00**

If you have any questions or comments concerning this matter, please feel free to contact us.

Sincerely,

/s/ Robin Bradley
Robin L Bradley
Reimbursement Analyst
Audit and Reimbursement
402-351-3919

Supreme Court, U.S.
FILED
JAN 29 2009
OFFICE OF THE CLERK

No. 08-558

In the Supreme Court of the United States

ROBERT I. BOURSEAU, ET AL., PETITIONERS

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

EDWIN S. KNEEDLER
Acting Solicitor General
Counsel of Record
MICHAEL F. HERTZ
Acting Assistant Attorney General
DOUGLAS LETTER
DANIEL R. ANDERSON
ROBERT J. MCAULIFFE
Attorneys
Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

QUESTIONS PRESENTED

1. Whether petitioners were properly held liable under the "reverse false claims" provision of the False Claims Act, 31 U.S.C. 3729(a)(7), based on their submission of Medicare cost reports in which petitioners overstated their reimbursable costs and thereby reduced or concealed their obligation to repay the Medicare program for overpayments.

2. Whether the government sustained damages from petitioners' submission of Medicare cost reports that reduced or concealed petitioners' obligation to make immediate repayment of overpayments that petitioners had received from the Medicare program.

3. Whether the court of appeals correctly held that the district court's award of treble damages did not violate the Excessive Fines Clause of the Eighth Amendment or the Due Process Clause of the Fifth Amendment.

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In the Supreme Court of the United States

No. 08-558

ROBERT I. BOURSEAU, ET AL., PETITIONERS

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-33) is reported at 531 F.3d 1159. The opinion of the district court (Pet. App. 34-70) and the district court's order amending the opinion and judgment (Pet. App. 73-80) are not published in the Federal Supplement but are available at 2006 WL 2961105 and 2006 WL 3949169, respectively.

JURISDICTION

The judgment of the court of appeals was entered on July 14, 2008. A petition for rehearing was denied on August 19, 2008 (Pet. App. 83-84). The petition for a writ of certiorari was filed on October 23, 2008. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. The Medicare program provides health insurance to persons 65 years of age and over, as well as to individuals receiving Social Security disability benefits. See 42 U.S.C. 1395c. Under Part A of the program, Medicae Act, 42 U.S.C. 1395c *et seq.*, Medicare beneficiaries are entitled to have payments made on their behalf to hospitals, including psychiatric hospitals, or to other Medicare providers as reimbursement for certain hospital care and related services. 42 U.S.C. 1395d (2000 & Supp. V 2005). Medicare reimburses providers for that portion of their reasonable cost of providing services that is incurred on behalf of Medicare beneficiaries. 42 U.S.C. 1395x(v)(1)(A). Fiscal intermediaries—private entities, generally insurance companies, acting pursuant to agreements with the Centers for Medicare and Medicaid Services—play a principal role in administering payments to Medicare providers. See 42 U.S.C. 1395h; 42 C.F.R. 421.3.[1]

In order to ensure adequate cash-flow to the providers, intermediaries make large estimated payments (called interim payments) to providers at frequent intervals, based on the provider's estimated treatment costs for Medicare patients, subject to reconciliation at the end of the cost reporting year. 42 U.S.C. 1395g(e) (2000 & Supp. V 2005); 42 C.F.R. 413.60, 413.64.[2] The regulatory scheme therefore specifically contemplates that

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[1] The fiscal intermediaries are now referred to as "Medicare administrative contractors." 42 U.S.C. 1395h(a) (Supp. V 2005).

[2] During the time period at issue in this case, psychiatric hospitals were reimbursed on a cost basis, see 42 C.F.R. Pt. 413, rather than under the prospective payment system, see 42 C.F.R. 412.400 *et seq.*, which was made applicable to psychiatric hospitals in 2005, see 42 C.F.R. 412.20(b).

providers will at times be overpaid and at other times underpaid. Each hospital annually submits to the appropriate intermediary a cost report that provides a final accounting of its actual costs for the year. 42 C.F.R. 413.20.

If the provider's cost report reflects that the Medicare program has overpaid the provider during the year, "a full refund is to be remitted with the report." United States Department of Health and Human Services, *Provider Reimbursement Manual* Pt. I, § 2409.1.A.2 (2005) (PRM).[3] If the cost report indicates that the provider was underpaid, the intermediary is directed to make a tentative retroactive adjustment, after correcting any obvious errors or inconsistencies in the cost report and offsetting any unrecovered overpayment. PRM § 2408.2; 42 C.F.R. 413.64(f)(2). After a more complete audit of the cost report, the intermediary issues a final notice of provider reimbursement (NPR) "reflecting the intermediary's determination of the total amount of reimbursement due the provider," which serves as "the basis for making the retroactive adjustment * * * to any program payments made to the provider during the period." 42 C.F.R. 405.1803.

When an intermediary believes either that a provider is involved in bankruptcy proceedings or that insolvency proceedings will shortly be instituted, the intermediary is directed to take steps to prevent overpayments to the provider. In such circumstances, "any payments to the provider will be adjusted by the intermediary, notwith-

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[3] The PRM "is an extensive set of informal interpretative guidelines and policies published [by the agency which administers the Medicare program] to assist intermediaries and providers in applying the reasonable cost reimbursement principles." *Providence Hosp.* v. *Shalala*, 52 F.3d 213, 218 (9th Cir. 1995).

standing any other regulation or program instruction regarding the timing or manner of such adjustments, to a level necessary to insure that no overpayment to the provider is made." 42 C.F.R. 413.64(i). The PRM similarly directs intermediaries not to make additional payments to potentially insolvent providers as part of a tentative initial adjustment based on the provider's cost report, but instead to wait until a final NPR is issued. PRM § 2408.2.

2. The United States filed this action against petitioners under the False Claims Act (FCA), 31 U.S.C. 3729 *et seq.*, and for unjust enrichment and common law fraud. The government alleged that petitioners had defrauded the Medicare program while operating Bayview Hospital and Mental Health Systems (Bayview), a California psychiatric hospital owned and operated by petitioners through their partnership California Psychiatric Management Services (CPMS). The government contended that petitioners had submitted various cost reports seeking reimbursement for costs that either were not actually incurred or were not eligible for Medicare reimbursement.

Under the FCA, persons who commit a variety of acts involving false claims against the federal government are liable to the United States for civil penalties "plus 3 times the amount of damages which the Government sustains because of the act of that person." 31 U.S.C. 3729(a). Section 3729(a)(7), commonly known as the FCA's "reverse false claims" provision, imposes liability upon any person who "knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government." 31 U.S.C. 3729(a)(7). The district court held that peti-

tioners had violated Section 3729(a)(7) by submitting their 1997, 1998, and 1999 cost reports, which decreased the amount CPMS owed Medicare by $5,219,195. Pet. App. 59-67; *id.* at 75. In particular, the court found that CPMS had fraudulently included in its cost reports interest ostensibly charged to CPMS by one of its creditors, which was never paid by CPMS and which was unrelated to the treatment of Medicare patients at Bayview; bankruptcy fees unrelated to care for Medicare patients; a fictitious rent expense; costs associated with space that was not used for patient care; and management fees paid to a related entity that provided no management services. *Id.* at 42-52. Pursuant to 31 U.S.C. 3729(a), the district court awarded the United States treble damages in the amount of $15,657,585, as well as $31,000 in civil penalties. Pet. App. 75.

3. The court of appeals affirmed. Pet. App. 1-33. Like the district court, the court of appeals concluded that the government had proved all the elements necessary to establish liability under the FCA's reverse false claims provision—*i.e.*, that petitioners had (1) knowingly (2) made, used, or caused to be made or used a record or statement that was (3) materially (4) false, (5) with the purpose to conceal, avoid, or decrease an obligation to pay money to the government. *Id.* at 10-27.

The court of appeals rejected petitioners' argument that the false costs claimed on the cost reports were not material to the implementation of the Medicare program. Pet. App. 25-27. Applying the standard established by this Court in *Neder* v. *United States*, 527 U.S. 1 (1999), the court of appeals concluded that the false statements contained in CPMS's cost reports "were material because they had the potential effect, or natural tendency, to decrease the amount CPMS owed Medicare

in overpayments." Pet. App. 27; see *id.* at 26 (quoting *Neder*, 527 U.S. at 16 ("[i]n general, a false statement is material if it has 'a natural tendency to influence, or [is] capable of influencing, the decision of the decision-making body to which it was addressed.") (brackets in original).

The court of appeals also rejected petitioners' contention that CPMS's fraudulent cost reports did not damage the United States. Pet. App. 27-31. The court explained that "[d]amages for a reverse false claim consist of the difference between what the defendant should have paid the government and what the defendant actually paid the government." *Id.* at 30. The court concluded that petitioners "had a legal obligation to pay the government money at the time they submitted the cost reports," *id.* at 23, and that "the difference between what CPMS should have repaid the government and what it did repay the government [was] $5,219,195," *id.* at 30. The court rejected petitioners' argument that their precarious financial position relieved them of any obligation to repay the overpayment. *Id.* at 27-28. The court explained that, under the relevant Medicare regulation, special care should be taken to *prevent* overpayments to potentially insolvent providers. *Id.* at 28 (citing 42 C.F.R. 413.64(i)).

The court of appeals rejected petitioners' argument that the district court's award of treble damages plus civil penalties violated petitioners' constitutional rights. Pet. App. 31-33. Examining the four relevant factors identified in *United States* v. *Mackby*, 339 F.3d 1013, 1016 (9th Cir. 2003), cert. denied, 541 U.S. 936 (2004), the court concluded that (1) making false claims to the government was a serious offense, (2) the government had sustained harm to its fiscal interests and to the in-

tegrity of the Medicare program, and (3) petitioners fell squarely within the class of persons targeted by the FCA. Pet. App. 33. The court found that one *Mackby* factor—the fact that the district court had imposed the maximum penalty permitted under the FCA—favored petitioners. *Id.* at 32. The court of appeals concluded, however, that nothing prohibited the district court from awarding the maximum amount, and that when all four factors were considered in the aggregate, the award was not grossly disproportionate to the gravity of petitioners' offenses. *Id.* at 33.

ARGUMENT

The court of appeals' decision is correct and does not conflict with any decision of this Court or of any other court of appeals. Further review is not warranted.

1. Petitioners contend (Pet. 14-18) that the false statements on their cost reports were not "material" to the government's administration of the Medicare program, and that the court of appeals' analysis of materiality conflicts with decisions of the Eighth Circuit. Contrary to petitioners' contention, the evidence in this case satisfied both the "natural tendency" test adopted by the Third, Fourth, Sixth, Seventh, Ninth, and Tenth Circuits, and the "outcome materiality test" that petitioners contend has been adopted by the Eighth Circuit.

a. Although the FCA does not contain a distinct materiality *element*, the submission of a false statement to a government official does not, in and of itself, violate the statute. The most commonly-invoked provision of the FCA imposes liability upon a person who "knowingly presents * * * [to the federal government] a false or fraudulent claim for payment or approval." 31 U.S.C. 3729(a)(1). When a defendant's asserted liability under

Section 3729(a)(1) is premised on a false statement made on or in connection with a claim form, the false statement will not render the "claim" itself "false or fraudulent" unless the statement is potentially relevant to the government's payment decision.

The FCA provision at issue in this case imposes liability on one who "knowingly makes [or] uses * * * a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government." 31 U.S.C. 3729(a)(7). Under Section 3729(a)(7), a false statement that has no potential bearing on the government's collection of funds is not appropriately characterized as being made or used "to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government." Thus, while the FCA contains no separate materiality element, the pertinent liability provisions require proof of a logical connection, substantively analogous to a requirement of "materiality" as that term has traditionally been understood, between a defendant's false statement and the government's payment or collection of money.

b. Petitioners contend (Pet. 11, 15) that, in order to establish that a defendant's misrepresentation was material under Section 3729(a)(7), the United States must prove that the defendant's actions actually deprived the government of money it was lawfully due. That argument lacks merit for at least three reasons.

i. In *Neder* v. *United States*, 527 U.S. 1 (1999), this Court stated that "actionable 'fraud' had a well-settled meaning at common law," and that "the well-settled meaning of 'fraud' required a misrepresentation or concealment of *material* fact." *Id.* at 22. Consistent with that traditional understanding, the Court construed the federal mail fraud, wire fraud, and bank fraud statutes

to contain a materiality requirement. *Id.* at 20-25. The Court further explained that, "[i]n general, a false statement is material if it has a natural tendency to influence, or is capable of influencing, the decision of the decision-making body to which it was addressed." *Id.* at 16 (brackets, internal quotation marks, and citation omitted).

The Court in *Neder* made clear, however, that a conviction under those federal fraud statutes does not require proof that the victim actually relied on the false representations or was damaged by the defendant's misconduct. See 527 U.S. at 24-25. The Court treated those elements of common-law fraud as separate from the requirement that a defendant's misrepresentations be material. See *ibid.* The Court held that "the elements of reliance and damage would clearly be inconsistent with the statutes Congress enacted" because those statutes refer to "'scheme[s] to defraud,' rather than the completed fraud." *Id.* at 25. In light of the *Neder* Court's holding that the government may prove materiality without proving reliance or damages, there is no basis for petitioners' contention that a misrepresentation is necessarily immaterial if it did not ultimately deprive the government of money it was lawfully due.

ii. The text of the FCA also does not support petitioners' contention that liability under the Act depends on proof of an actual effect on the government's payment or recoupment decision. Under 31 U.S.C. 3729(a)(1), any person who "knowingly presents" a "false or fraudulent claim" to the federal government is liable for damages and civil penalties. Because Section 3729(a)(1) attaches liability upon *presentment* of a false or fraudulent claim, rather than *actual payment* on that claim, the question whether the provision was violated in a particular case

should be resolved based on the facts as they existed at the time of presentment. Whether a particular false statement would have the "natural tendency" to affect the government's payment decision can be determined without reference to events (such as the government's actual disposition of the claim) that postdate the claim's submission. Thus, just as Congress's decision to prohibit certain "scheme[s] to defraud" was held to reflect a decision not to require proof of reliance and damages under the federal fraud statutes at issue in *Neder*, see 527 U.S. at 24-25, Congress's focus on the "present-[ment]" of false claims under 31 U.S.C. 3729(a)(1) manifests a similar intent.

Similarly, the reverse false claims provision, Section 3729(a)(7), focuses on the "mak[ing]" or "use[]" of false records or statements. Although Section 3729(a)(7) imposes the additional requirement that the false record or statement be made or used "to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government," that language is most sensibly construed simply to require a logical connection between the false record or statement and a defendant's obligation to pay money or property to the United States. Section 3729(a)(7) requires knowing concealment or avoidance, but it does not require that the defendant's misconduct culminate in any particular result. See *United States ex rel. A+ Homecare, Inc.* v. *Medshares Mgmt. Group, Inc.*, 400 F.3d 428, 445-446 (6th Cir.), cert. denied, 546 U.S. 1063 (2005). And there is no reason to suppose that Congress, having focused on the *potential* (rather than the actual) effect of a claimant's conduct in 31 U.S.C. 3729(a)(1), would require proof of an actual impact on the federal fisc in the later-enacted Section 3729(a)(7). To the contrary, the legislative history

strongly indicates that the two provisions should be construed *in pari materia*. See S. Rep. No. 345, 99th Cong., 2d Sess. 18 (1986) (Section 3729(a)(7) "provide[s] that an individual who makes a material misrepresentation to avoid paying money owed the Government would be equally liable under the Act as if he had submitted a false claim to receive money."); H.R. Rep. No. 660, 99th Cong., 2d Sess. 20 (1986) (Section 3729(a)(7) reflects the view "that there is no reason to treat a false claim filed against the Government to fraudulently reduce an obligation owed to the Government differently from one filed for the purpose of fraudulently obtaining money.").

iii. "[E]valuating materiality based on the potential effect rather than actual result is more consistent with the underlying purpose of the FCA." *A+ Homecare*, 400 F.3d at 446. This Court "has broadly interpreted the statute to cover 'all fraudulent *attempts* to cause the Government to pay out sums of money.'" *Ibid.* (quoting *United States* v. *Neifert-White Co.*, 390 U.S. 228, 233 (1968)). The logical implication of petitioners' theory, however, is that a claimant who seeks to obtain government funds through fraud will escape FCA liability altogether if the government detects the misrepresentation before payment is made and thereby avoids an actual financial loss. Creation of such a loophole would subvert Congress's intent to deal comprehensively with efforts to obtain federal money or property by dishonest means.

c. The court of appeals concluded that the false statements on petitioners' cost reports "were material because they had the potential effect, or natural tendency, to decrease the amount CPMS owed Medicare in overpayments, despite the fact that cost reports were never audited." Pet. App. 27. That conclusion is consistent with the Sixth Circuit's ruling in *A+ Homecare*, the

only other appellate decision directly on point. As in this case, the defendant in *A+ Homecare* included a false cost in its cost report, but the intermediary delayed completing its audits pending the outcome of the fraud investigation. *A+ Homecare*, 400 F.3d at 456.[4] The Sixth Circuit concluded that, under Section 3729(a)(7), a court's determination of materiality should be "based on the potential effect rather than actual result" of the defendant's false statement, *id.* at 446, and that the intermediary's failure to complete the audit was "irrelevant in this case * * * because the mere act of placing the false accrual on the Cost Report is sufficient to find [defendant] liable under the FCA," *id.* at 446 n.13. The same analysis applies here.

d. The Ninth Circuit's "natural tendency" test is consistent with the standard for FCA liability adopted by five other circuits. Those courts have recognized that, so long as the defendant's false statements reasonably *could have* influenced the government's payment or collection of money, the FCA does not require proof of any actual fiscal impact. See *United States* v. *Rogan*, 517 F.3d 449, 452 (7th Cir. 2008); *United States ex rel. Bahrani* v. *Conagra, Inc.*, 465 F.3d 1189, 1204 (10th Cir. 2006), cert. denied, 128 S. Ct. 388 (2007); *A+ Homecare*,

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[4] Petitioners assert that their fraudulent cost reports were not audited because the fiscal intermediary knew of CPMS's precarious financial situation and the PRM precludes any action with respect to the cost reports of a provider suspected of insolvency. Pet. 6, 8, 17, 22-23. As discussed below, petitioners misunderstand the pertinent regulatory and PRM provisions. See p. 17, *infra*. Moreover, petitioners are incorrect as a factual matter. The trial record disclosed that the intermediary discontinued its audit because, after receiving an allegation of fraud, the Medicare program initiated an investigation culminating in this FCA action by the United States. See C.A. E.R. 242-243; C.A. Supp. E.R. 25-26.

400 F.3d at 446; *United States ex rel. Harrison* v. *Westinghouse Savannah River Co.*, 352 F.3d 908, 913, 916-917 (4th Cir. 2003); *United States ex rel. Cantekin* v. *University of Pittsburgh*, 192 F.3d 402, 415-416 (3d Cir. 1999), cert. denied, 531 U.S. 880 (2000).

Petitioners contend (Pet. 11, 15) that the court of appeals' decision in this case conflicts with the Eighth Circuit's decision in *Costner* v. *URS Consultants, Inc.*, 153 F.3d 667, 677 (1998) (*Costner I*). Petitioners construe the decision in *Costner I* as requiring the government to show "that the defendants' actions actually caused the United States to pay out money it was not obligated to pay or actually deprived the United States of money it was lawfully due." Pet. 11. The Ninth Circuit in this case likewise understood the Eighth Circuit to have applied an "outcome materiality test," which the Ninth Circuit regarded as inconsistent with its own "natural tendency" standard. Pet. App. 26. For two reasons, any tension between the legal standards adopted by the Ninth and Eighth Circuits in this area provides no basis for further review here.

i. More recent decisions of the Eighth Circuit indicate that the court has not yet settled on a precise standard for defining the circumstances under which a defendant's misrepresentations will give rise to FCA liability. In *United States ex rel. Costner* v. *United States*, 317 F.3d 883, cert. denied, 540 U.S. 875 (2003) (*Costner II*), the Eighth Circuit characterized its earlier decision in *Rabushka ex rel. United States* v. *Crane Co.*, 122 F.3d 559, 563 (1997), cert. denied, 523 U.S. 1040 (1998), as merely "*suggest*[*ing*] that outcome materiality is the proper standard," and similarly regarded *Costner I* as only "*impl*[*ying*] a materiality standard stricter than mere relevancy." *Costner II*, 317 F.3d at 887 (emphases

added). The court in *Costner II* concluded that it "need not decide the precise contours of the materiality requirement" because there was no evidence to show that the defendant's alleged false statement "was even relevant to [the agency's] payment decision." *Ibid.*

The Eighth Circuit subsequently reiterated that *Costner II* had "confirmed that a showing of materiality is implicit in the FCA, though we did not define 'the precise contours' of this requirement." *Hays* v. *Hoffman*, 325 F.3d 982, 992, cert. denied, 540 U.S. 877 (2003) (quoting *Costner II*, 317 F.3d at 887). In *Hays*, the defendants conceded in their reply brief "that the false claims were material if they were capable of influencing the government's payment decision." *Ibid.* (internal quotation marks and citation omitted). The Eighth Circuit noted that "[t]he district court's instructions included that concept in a definition of materiality," and the court further observed that the defendant's false representations were "capable of influencing, and did in fact influence, the government's Medicaid reimbursement decisions." *Ibid.* The court of appeals concluded that "the instructions 'taken as a whole and viewed in light of the evidence and the applicable law, fairly and adequately submitted the issues in the case to the jury.'" *Ibid.* (quoting *Gray* v. *Bicknell*, 86 F.3d 1472, 1485 (8th Cir. 1996)). *Costner II* and *Hays* suggest that the Eighth Circuit has thus far declined to choose between the "natural tendency" test employed by the court of appeals in this case, and the more demanding "outcome materiality" standard advocated by petitioners. Because the Eighth Circuit has not defined the "precise contours" (*Costner II*, 317 F.3d at 887) of its materiality standard and has not unequivocally chosen the standard petitioners urge, any tension between the existing Ninth

and Eighth Circuit precedents does not warrant this Court's review.

ii. Even if a fully developed circuit conflict did exist, this case would be an unsuitable vehicle for resolving it, because there is no reason to suppose that petitioners would have escaped FCA liability under the "outcome materiality" standard that petitioners advocate. The FCA's reverse false claims provision imposes liability on any person who knowingly uses "a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government." 31 U.S.C. 3729(a)(7). As the court of appeals correctly explained, petitioners "had a legal obligation to pay the government money at the time they submitted the cost reports." Pet. App. 23; see *id.* at 58 ("Hospitals are required to remit a full refund of overpayments to Medicare at the time they file their cost reports."); see also PRM § 2409.1.A.2 ("When the provider files a cost report indicating that an overpayment has occurred a full refund is to be remitted with the report."). Petitioners' fraudulent conduct therefore resulted in a different "outcome"—*i.e.*, a failure to repay the Medicare program the amount that an accurate cost report would have identified as due and owing—than would have occurred if petitioners had complied with their legal obligations. Petitioners do not contend that any decision of the Eighth Circuit has held Section 3729(a)(7) to be inapplicable in circumstances like these.

This Court recently denied a petition for a writ of certiorari regarding the FCA's materiality standard from the Sixth Circuit's decision in *A+ Homecare*, in which the court of appeals upheld an FCA judgment in a Medicare reimbursement case substantially similar to this one. See *Winters* v. *United States ex rel. A+*

Homecare, Inc., 546 U.S. 1063 (2005). There is no reason for a different result in this case.

2. The court of appeals correctly concluded (Pet. App. 27-30) that petitioners' false cost reports damaged the United States. Contrary to petitioners' contention (Pet. 17-19), that holding does not conflict with the decisions of any other court of appeals.

a. Petitioners contend that the government could not prove damages in this case because it could not show that it "relied on a false claim or representation in making a payment decision." Pet. 17 (citing *United States ex rel. Schwedt* v. *Planning Research Corp.*, 59 F.3d 196, 199-200 (D.C. Cir. 1995), cert. denied, 516 U.S. 1068 (1996)). Unlike *Schwedt*, however, this case involves the FCA's reverse false claims provision, which prohibits the making or use of "a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government." 31 U.S.C. 3729(a)(7). Both in general and in this case, the harm that can naturally be expected to result from a violation of Section 3729(a)(7) is a failure by the government to *receive* funds owed to the United States, rather than the *disbursement* of federal money to persons who are not entitled to receive it.

There is consequently no basis for petitioners' contention (Pet. 17), in a suit filed under Section 3729(a)(7), that the government's ability to prove damages depended on evidence that it "relied" on petitioners' false statements in "making a payment decision." As explained above (see p. 15, *supra*), the court of appeals correctly held that petitioners "had a legal obligation to pay the government money at the time they submitted the cost reports" showing an overpayment by the Medicare program. Pet. App. 23; see *id.* at 58; PRM § 2409.1.A.2.

The government therefore was damaged when petitioners submitted cost reports that fraudulently reduced the amount that CPMS was required to repay the government.

Petitioners contend that immediate reimbursement of any overpayment is required "*unless* the provider was in bankruptcy or insolvent, which was the case here." Pet. 22; see Pet. 6 (contending that, under PRM § 2408.2, "no action is taken on a cost report submitted by a provider when the provider is potentially insolvent or is the subject of bankruptcy proceedings"). The court of appeals correctly rejected that reading of the pertinent regulatory and PRM provisions. See Pet. App. 27-28. Rather than relieving potentially insolvent providers of any obligation to repay overpayments, the provisions at issue protect *the Medicare program* by directing intermediaries to take particular care to avoid overpayments to such providers. The applicable Medicare regulation provides that, "notwithstanding any other regulation or program instruction regarding the timing or manner of such adjustments," when an intermediary believes that a provider may be insolvent, "any payments to the provider will be adjusted by the intermediary * * * to a level necessary to insure that no overpayment to the provider is made." 42 C.F.R. 413.64(i). The PRM similarly states that the intermediary should not make a tentative adjustment payment to a potentially insolvent provider on the basis of the provider's unaudited cost report. PRM § 2408.2. In any event, to the extent that petitioners' disagreement with the court of appeals' damages analysis turns on the proper interpretation of the Medicare regulations and the PRM, petitioners do not allege a conflict in the circuits on that issue, nor do they identify any other reason that the dis-

puted question of Medicare law would warrant this Court's review.

b. Petitioners also contend (Pet. 23) that the United States was not damaged by petitioners' fraud because the intermediary took no action to collect even the fraudulently reduced amounts that CPMS's cost reports acknowledged had been overpaid by the Medicare program. That assertion is factually inaccurate. By filing a claim in the bankruptcy proceedings, the government has attempted to collect the overpayments that were acknowledged on CPMS's cost reports but that CPMS did not immediately remit. Pet. App. 35.

Even if the government had forgone any effort to collect the smaller amount of CPMS's *acknowledged* debt to the Medicare program, the United States would still have been damaged by petitioners' fraudulent understatement of the sum owed to the United States and their attendant failure to pay that additional debt. In arguing that the government was not harmed by their fraudulent conduct, petitioners appear to contend (see Pet. 23) that, because the intermediary made no effort to collect the smaller amount that petitioners conceded was owed, it would likewise have ignored the much larger debt that an accurate cost report would have identified if petitioners had acknowledged the existence of the larger debt but had failed to pay it when the cost report was submitted. That contention is both factually speculative and legally flawed. To determine whether (and how greatly) the government was harmed by petitioners' fraudulent understatement of CPMS's debt to the United States, the courts below correctly took as their point of comparison the money that the government would have obtained if petitioners had fully complied with their legal obligations—*i.e.*, if they had ac-

knowledged the additional debt *and had promptly paid it* in accordance with applicable Medicare rules.

c. Petitioners contend (Pet. 17, 23-24) that the court of appeals' damages analysis conflicts with that of the D.C. Circuit in *Schwedt*. As noted above, however, the court in *Schwedt* did not construe the FCA's reverse false claim provision, but rather addressed the requirements for showing damages in an FCA action for submitting "a false or fraudulent claim for payment or approval," 31 U.S.C. 3729(a)(1), or submitting "a false record or statement to get a false or fraudulent claim paid or approved," 31 U.S.C. 3729(a)(2). See *Schwedt*, 59 F.3d at 199. In that context, the court held that reliance on the false record, statement, or claim in making or approving a payment was necessary to prove damages. *Id.* at 200.

A violation of Section 3729(a)(7), by contrast, injures the United States whenever the wrongdoer fails to pay the government the fraudulently concealed debt, even though no federal official relies on the false statement in making any payment decision.[5] To the extent petitioners rely on *Schwedt* for the broader proposition that damages are allowable under the FCA only if they were proximately caused by the defendant's fraud, 59 F.3d at 200, the decision of the court of appeals is not to the contrary. Rather, the court determined that $5,219,195 was "the difference between what CPMS should have repaid the government and what it did repay the government"

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[5] The Fifth and Third Circuit decisions on which the court in *Schwedt* relied, see 59 F.3d at 200 (citing *United States* v. *Hibbs*, 568 F.2d 347 (3d Cir. 1977), and *United States* v. *Miller*, 645 F.2d 473 (5th Cir. 1981)), are similarly distinguishable because neither involved reverse false claims.

and further confirmed that "none of the disputed costs was allowable." Pet. App. 30-31.

3. The court of appeals correctly rejected petitioners' constitutional challenges to the treble damages award against them, see Pet. App. 31-33, and that holding does not conflict with the decision of any other court of appeals.

a. Petitioners contend (Pet. 20) that the court of appeals adopted a categorical rule that "a District court is prohibited from reducing a judgment below statutory limits based on the excessive fines clause." The court of appeals issued no such holding. Rather, the court applied its earlier decision in *United States* v. *Mackby*, 339 F.3d 1013, 1016 (9th Cir. 2003), cert. denied, 541 U.S. 936 (2004), which, consistent with this Court's decision in *United States* v. *Bajakajian*, 524 U.S. 321 (1998), concluded that an award violates the Excessive Fines Clause if it is grossly disproportionate to the gravity of the defendant's conduct, *Mackby*, 339 F.2d at 1016. See Pet. App. 32. The court in *Mackby* identified four factors to be considered in determining whether an award is grossly disproportionate: (1) the severity of the offense and its relation to other criminal activity; (2) the maximum penalty faced; (3) the harm caused; and (4) whether the defendant falls within a class of persons targeted by the applicable law. 339 F.3d at 1016-1017.

In this case, the court of appeals concluded that the first, third, and fourth *Mackby* factors favored the United States because (1) making false claims to the government is a serious offense, (2) the government sustained harm to its fiscal interests and to the integrity of the Medicare program, and (3) petitioners fell squarely within the class of people targeted by the FCA. Pet. App. 33. The court found that the second *Mackby* factor

favored petitioners "because the district court imposed treble damages and the maximum amount of allowable civil penalties." *Id.* at 32. Looking at all four factors together, the court of appeals concluded that the award was not grossly disproportionate to the gravity of petitioners' offenses. *Id.* at 33.

That conclusion was correct. Petitioners caused the making of false statements and false reports in order to reduce by more than $5 million the amount CFMS owed Medicare, and that amount has never been repaid. Based on that conduct, the district court imposed judgment against petitioners for $15,657,585 in treble damages and for a civil penalty of $31,000. Pet. App. 75. That award is no more excessive than the treble damages awarded against the defendant in *A+ Homecare*, 400 F.3d at 454, or the award of nearly 12 times the government's damages upheld in *Mackby*, 339 F.3d at 1015-1019.

b. Petitioners' challenge under the Fifth Amendment's Due Process Clause (Pet. 20-21) also lacks merit. As the district court noted, an FCA damages award is not the product of a jury verdict and does not have the potentially arbitrary quality of a classic punitive damages award. Pet. App. 78-79. Moreover, treble damages are well within the suggestion in *State Farm Mutual Automobile Insurance Co.* v. *Campbell*, 538 U.S. 408, 425 (2003), that single-digit multiples of compensatory damages do not run afoul of the Due Process Clause. See Pet. App. 79 n. 3. And as this Court recognized in *Cook County* v. *United States ex rel. Chandler*, 538 U.S. 119 (2003), some part of an FCA award "beyond the amount of the fraud is usually 'necessary to compensate the Government completely for the costs, delays, and inconveniences occasioned by fraudulent claims,'" *id.* at

130 (quoting *United States* v. *Bornstein*, 423 U.S. 303, 315 (1976)), and for the unavailability of prejudgment interest and other consequential damages, *id.* at 131. The Court in *Chandler* explained that, while treble damages under the FCA "will exceed full compensation in a good many cases," *ibid.*, they are significantly different from "classic punitive damages," *id.* at 132.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

EDWIN S. KNEEDLER
Acting Solicitor General
MICHAEL F. HERTZ
Acting Assistant Attorney General
DOUGLAS LETTER
DANIEL R. ANDERSON
ROBERT J. MCAULIFFE
Attorneys

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